Calendar No. 1048

100TH CONGRESS
2d Session

SENATE

REPORT
100-580

NATIVE HAWAIIAN HEALTH CARE IMPROVEMENT ACT

SEPTEMBER 30 (legislative day, SEPTEMBER 26), 1988.—Ordered to be printed

Mr. INOUYE, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 136]

The Select Committee on Indian Affairs, to which was referred the bill (S. 136) to improve the health status of Native Hawaiians, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill (as amended) do pass.

PURPOSE

The purpose of S. 136 is to improve the health status of Native Hawaiians through the establishment of a comprehensive health promotion and disease prevention effort that involves health education in Native Hawaiian communities, and the provision of primary care health care services using traditional Native Hawaiian healers and health care providers trained in Western medicine. In areas where there is an underutilization of existing health care delivery systems that have the capacity to provide culturally-relevant, S. 136 provides authority for the Secretary of the Department of Health and Human Service to enter into contracts with Native Hawaiian organizations to provide health care referral services to Native Hawaiian patients.

S. 136 does not contemplate the establishment of a new bureaucratic system within the U.S. Department of Health and Human Services, nor does it contemplate that the responsibilities assigned to the Secretary of the Department of Health and Human Services would be carried out through a delegation of authority to the Indian Health Service. Rather, S. 136 authorizes the Secretary to enter into contracts with Native Hawaiian organizations, to carry out the purposes of the Act.

S413-26

S. 136 is premised upon the findings and recommendations of the Native Hawaiian Health Research Consortium report to the HHS Secretary of December, 1985. That report clearly indicates that the underutilization of existing health care services by Native Hawaiians can be traced to the absence of culturally relevant services, in which traditional Native Hawaiian concepts of healing are lacking, as well as to a general perception in the Native Hawaiian community that health care services which are fundamentally based on concepts of Western medicine, will not effect the healing or cure of diseases and illnesses afflicting Native Hawaiian people.

BACKGROUND

The islands that now compose the State of Hawaii were governed by a monarchy of Native Hawaiians until 1893. The Native Hawaiian government was recognized as an independent sovereign nation by foreign governments, and treaty relationships were established with the United States (Treaty of Friendship, Commerce, and Navigation of 1849; Treaty of Commercial Reciprocity, January 30, 1875.) As a result of expanded trade with the United States, western influence in the islands increased, and in 1893, the government of Queen Liliuokalani was overthrown in an insurrection engineered by a group of western businessmen in an effort tc secure the annexation of Hawaii to the United States. The United States minister in Hawaiii ordered one company of marines and two companies of sailors to be landed, and the minister then recognized a new provisional government even before Queen Liliuokalani's lines of defense had surrendered. Although the provisional government sought immediate annexation by the United States, President Grover Cleveland refused to submit a treaty of annexation to the Senate, finding that the provisional government lacked the popular support of the Native Hawaiian population and that the government would not have been established but for the lawless and unauthorized military intervention of the United States. Upon the inauguration of William McKinley as the new President of the United States in 1897, however, the western businessmen that sought annexation were able to change the official U.S. position, and in 1898, Hawaii became a territory of the United States.

During the first two decades of the twentieth century, the already depressed economic conditions of Native Hawaiians deteriorated further, and in 1920, the United States Congress legislated directly for the benefit of Native Hawaiians by enacting the Hawaiian Homes Commission Act, and establishing a land base for Native Hawaiians in order to encourage agricultural pursuits. The Act placed approximately 200,000 acres under the jurisdiction of the Hawaiian Homes Commission, a branch of the territorial government for the purpose of "rehabilitating" persons of at least fifty percent Native Hawaiian ancestry through a return to pastoral life. The Act also authorized the Commission to undertake "activities having to do with the economic and social welfare of the homesteaders."

Hawaii was admitted to statehood in 1959, and the Admission Act transferred the title to the lands of the Hawaiian Homes Commission from the Federal Government to the state. The state was

given administrative powers over the land in return for the state's acceptance of a trust responsibility for administering the lands. The Admission Act, however, retained authority in the Federal government to enforce the trust. The language of the Admission Act, however, retained authority in the Federal government to enforce the trust. The language of the Admission Act requires the state to hold the lands "as a public trust . . . for the betterment of the conditions of Native Hawaiians . . . and their use for any other object shall constitute a breach of trust for which suit may be brought by the United States."

Language contained in Public Law 98-396, 1984 Supplemental Appropriations Act, directed the Department of Health and Human Services to conduct a comprehensive study of the health care needs of Native Hawaiians. The study was conducted under the aegis of Region IX of the Department by a consortium of health care providers and professionals from the State of Hawaii in a predominantly volunteer effort, organized by Alu Like, Inc., a Native Hawaiian organization. An island-wide conference was held in November of 1985 in Honolulu to provide an opportunity for members of the Native Hawaiian community to review the study's findings. Recommended changes was incorporated in the final report of the Native Hawaiian Health Research Consortium, and the study was formally submitted to the Department of Health and Human Services in December of 1985. The Department submitted the report to the Congress on July 21, 1986, and the report was referred to the Select Committee on Indian Affairs.

Because the Consortium reports' findings as to the health status of Native Hawaiians was compared only to other populations within the State of Hawaii, the Select Committee requested that the Office of Technology Assessment (OTA), an independent agency of the Congress, undertake an analysis of Native Hawaiian health statistics as they compared to national data in other United States populations. Using the same population projection model that was employed in OTA's April 1986 report on *Indian Health Care* to American Indian and Alaska Native populations, and based on additional information provided by the Department of Health and the Office of Hawaiian Affairs of the State of Hawaii, the Office of Technology Assessment report contains the following findings:

"The Native Hawaiian population living in Hawaii consists of two groups, Hawaiians and part-Hawaiians, who are distinctly different in both age distributions and mortality rates. Hawaiians comprise less than five percent of the total Native Hawaiian population and are much older than the young and growing part-Hawaiian populations.

"Overall, Native Hawaiians have a death rate that is thirty-four percent higher than the death rate for the United States all races, but this composite masks the great differences that exist between Hawaiians and part-Hawaiians. Hawaiians have a death rate that is 146 percent higher than the U.S. all races rate. Part-Hawaiians also have a higher death rate, but only 17 percent greater. A comparison of age-adjusted death rates for Hawaiians and part-Hawaiians reveals that Hawaiians die at a rate 110 percent higher than part-Hawaiians, and this pattern persists for all except one of the

13 leading cause of death that are common to both groups (See Table 11).

"As in the case of the U.S. all races population, Hawaiian and part-Hawaiian males have higher death rates than their female counterparts. However, when Hawaiian and part-Hawaiian males and females are compared to their U.S. all races counterparts, females are found to have more excess deaths than males. Most of these excess deaths are accounted for by diseases of the heart and cancers, with lesser contributions from cerbrovascular diseases and diabetes mellitus.

"Diseases of the heart and cancers account for more than half of all deaths in the U.S. all races population, and this pattern is also found in both the Hawaiian and part-Hawaiian populations, whether grouped by both sexes or by male or female. However, Hawaiians and part-Hawaiians have significantly higher death rates than their U.S. all races counterparts, with the exception of part-Hawaiian males, for whom the death rate from all causes is approximately equal to that of U.S. all race males.

"One disease that stands out is diabetes mellitus, for which even part-Hawaiian males have a death rate 128 percent higher than the rate for U.S. all races males. (See Table 9). Overall, Native Hawaiians die from diabetes at a rate that is 222 percent higher than for the U.S. all races. (See Table 2). When compared to their U.S. all races counterparts, deaths from diabetes mellitus range from 630 percent higher for Hawaiian females and 538 percent higher for Hawaiian males, to 127 percent higher for part-Hawaiian females and 128 percent higher for part-Hawaiian males."

Current Health Status and Population Projections of Native Hawaiians Living in Hawaii

INTRODUCTION

Federal legislation to address the health needs of Native Hawaiians living in the State of Hawaii was initiated by the Senate in the 99th Congress and is again under consideration in the current 100th Congress. Past efforts were included in legislation to reauthorize the Indian Health Care Improvement Act, which was first enacted into law in 1976 and reauthorized in 1980. In 1984, President Reagan vetoed reauthorization of the Act, but Congress has continued to appropriate funds through a Continuing Resolution for most of the programs covered by the Act. Toward the end of the 99th Congress in late 1986, the Senate Select Committee on Indian Affairs, in its bill reauthorizing the Act, included provisions for a Native Hawaiian health professions scholarship program and a health promotion and disease prevention scholarship program and a health promotion and disease prevention demonstration project for Native Hawaiians living in Hawaii. Similar efforts are underway in the 100th Congress, but in legislative proposals that have been separated from the continuing efforts to reauthorize the Indian Health Care Improvement Act.

In April 1986, the Office of Technology Assessment (OTA) published its report on *Indian Health Care* (12), which had been requested by the House Energy and Commerce Committee and its Subcommittee on Health and the Environment. This request had

been supported by the Senate Select Committee on Indian Affairs and by the Chairman and Vice-Chairman of OTA's Congressional Board, one of whom was also acting in his capacity as Chairman of the House Interior and Insular Affairs Committee. Among the information provided in the OTA report were: (1) comparisons of the health status of American Indians and Alaska Natives with the health status of the overall United States' population, and (2) projections of the future American Indian and Alaska Native populations. One consequence of this report was a request by the Senate Select Committee on Indian Affairs to develop similar comparisons and projections for the Native Hawaiian population living in the State of Hawaii.

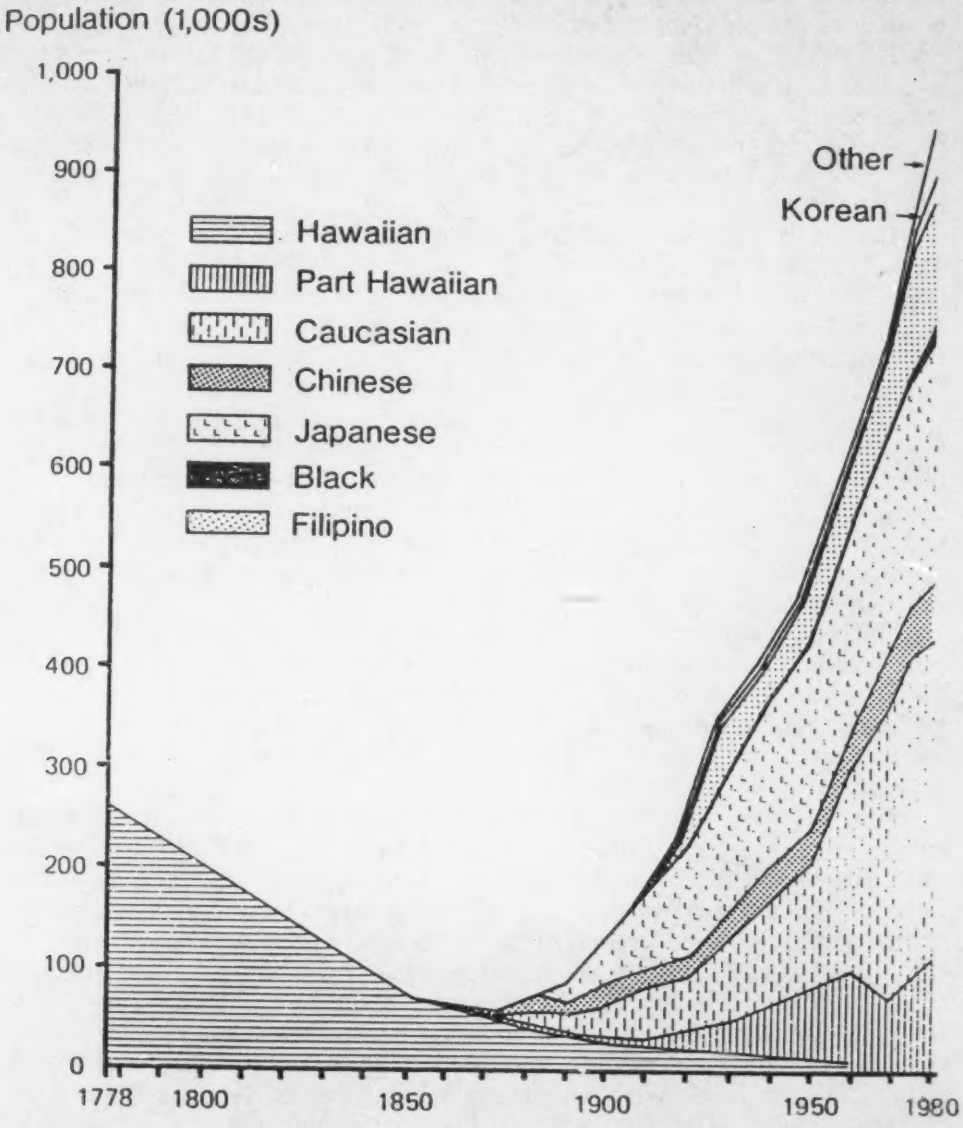
In August 1986, comparisons of the leading causes of mortality of Native Hawaiians in Hawaii with that of the U.S. All Races population were provided to the Senate Select Committee on Indian Affairs, other interested congressional committees, members of the Hawaii congressional delegation, and organizations in Hawaii (13). Projections of the Native Hawaii population in Hawaii have been developed and are reported here, using the same population projection model (under contract with The Futures Group) that was applied to the American Indian and Alaska Native populations, and based on information provided by the Department of Health and the Office of Affairs of the State of Hawaii. The previously provided information on Native Hawaiian mortality is also presented here in modified form.

"Native Hawaiians" are comprised of two groups: (1) "Hawaiians," or persons identified as being essentially of pure Hawaiian blood, and (2) "Part-Hawaiians," or persons who have a significant degree of Hawaiian blood. There are two data sources from which estimates of the number of Native Hawaiians living in Hawaii can be made.

Prior to the 1970 U.S. Census, Hawaiians were identified separately from Part-Hawaiians, but from 1970 on, the U.S. Census did not differentiate between "pure" and "part" Hawaiians. The Census asked all persons (on the "short form") to select the ethnic group which best described them, and also asked some persons (on the "long form") about their ancestry. The 1980 Census counted 118,251 persons living in Hawaii who considered themselves "Hawaiians" and 136,341 persons with some degree of Hawaiian ancestry (14). Figure 1 summarizes the resident population of Hawaii from 1778 to 1980, with the most recent years derived from U.S. Census data (3). (In Figure 1, all Native Hawaiians are aggregated as "Part-Hawaiian" after 1960, and the apparent decrease in 1970 in an artifact resulting from changes in the way the Native Hawaiian population was identified in the U.S. Census.)

Figure 1

RESIDENT POPULATION OF HAWAII, 1778–1980



Source: Nordyke, E.C., The Peopling of Hawaii, Revised Edition, University of Hawaii Press (forthcoming)

The Department of Health of the State of Hawaii also conducts an annual Health Surveliance Program, in which a sample (approximately 2 percent) of the non-institutionalized resident population is surveyed in order to estimate overall population characteristics. Households excluded from this sample are the areas of Kalawao County (Molokai Island) and the Island of Niihau (both of which have significant percentages of Native Hawaiians living there, although the absolute numbers are small), and the institutional population: (1) in military barracks, (2) in college dormitories, (3) in institutions such as mental hospitals, homes for the aged, and prisons, (4) aboard ships, and (5) in other unspecified group quarters (4).

As part of this annual survey, respondents are asked to identify the race or combination of races of their father and mother. If a combination of races is present, respondents are asked to enter only up to the 3 major ones. "Hawaiians" thus are represented by respondents with both parents identified as Hawaiian only, and "Part-Hawaiians" are represented by respondents who have at least one parent with Hawaiian blood. Respondents are placed in one of eight possible racial categories: Caucasian, Japanese, Filipino, Chinese, Pure Hawaiian, Other Pure Unknown, Mixed: Part-Hawaiian, and Mixed: Non-Hawaiian and Others. In the period 1980–1985, there was an estimated average annual population of 184,841 Native Hawaiians living in Hawaii: 8,134 Hawaiians, and 176,707 Part-Hawaiians (9). The 1980 Health Surveillance Program estimated that there were 175,909 Native Hawaiians living in Hawaii. This is in contrast to the 1980 U.S. Census count of 118,251 persons who considered themselves Native Hawaiians and 136,341 persons with some degree of Native Hawaiian ancestry living in Hawaii (see above).

The Health Surveillance Program is considered the more reliable source for identifying Native Hawaiians and is used in this analysis as the base population for the mortality comparisons and population projections. The population projections are also based on the assumption that migration of Native Hawaiians in and out of the State of Hawaii is approximately equal. The year-to-year estimates from the annual Health Surveillance Program do not reveal marked variations, thereby supporting the assumption that migration of Native Hawaiians in and out of Hawaii to the "mainland" states is approximatley equal. However, the 1980 Census, in which 118,251 Native Hawaiians were identified as living in Hawaii, also revealed that there were a total of 172,346 Native Hawaiians living in the United States. Thus, approximately one-third of Native Hawaiians already live outside of Hawaii. The population projections presented later assume that descendants of the present population of Native Hawaiians living in Hawaii will all continue to live in Hawaii (this and other limitations of the population projection model are discussed in more detail later in this report; all of these limitations are biased toward overestimating the future population of Native Hawaiians living in Hawaii).

Mortality data are derived from the Vital Statistics Office of the Hawaii State Department of health. If a person's race is not known, the racial/ethnic identity of the deceased person's father is ascribed to the decedent. Thus, there will be some degree of under-

counting of deaths in the Native Hawaiian population when compared to the Native Hawaiian population estimates that are derived from the Health Surveillance Program (i.e., if the decedent's mother, but not father, was Hawaiian or Part-Hawaiian). This means that the mortality rates that are presented are somewhat underestimated, but probably not to a degree that would significantly affect the general comparisons between the Native Hawaiian population residing in Hawaii and the U.S. All Races population. The Native Hawaiian mortality rate is affected more by the use of the Health Surveillance Program's population estimate (175,909 in 1980) instead of using the number of persons who identified themselves as Hawaiian (118,251) or with some degree of Hawaiian ancestry (136,341) in the 1980 U.S. Census. Thus, if U.S. Census population estimates were used, the mortality rates presented here would have been much higher.

The actual death rate is obtained by dividing the number of deaths by the number of people, and expressing the result in standard terms, such as the yearly number of deaths per 100,000 persons. However, one of the factors affecting mortality rates is the age distribution of the population being analyzed. For example, if one population is made up predominantly of older persons while another has a majority of much younger persons and comparisons of the actual mortality rates are made, the older population would have a higher rate, but this would not necessarily mean that the older population was in worse comparative health. We would expect, for example, that more persons in the age group 65 years and older would die in any given year than among an equal number of persons who were between the ages of 25 and 35 years. Thus, a more appropriate comparison would be to calculate age-specific death rates and "adjust" the actual death rates to take into account differences in the age distribution of the populations being compared. The adjustment of actual death rates is labeled "age-adjusted mortality rates" and is the standard method used when comparing populations (or in following one population over the course of time).

In determining mortality rates for the "U.S. All Races" population, the U.S. National Center for Health Statistics (NCHS) compares yearly changes through the use of age-adjusted mortality rates. The reason is that the U.S. population has grown progressively older, and actual death rates have in turn progressively increased. Without the use of age-adjusted mortality rates, the misleading impression would be that the health of our population is worsening, when in fact it might simply be reflecting the normally higher mortality that accompanies an aging population. Thus, each year, NCHS standardizes its mortality rates by age-adjusting them to a reference population, which is the U.S. population as it existed in 1940. The age-adjusted mortality rates presented here for Native Hawaiians have also been standardized against the reference U.S. population, which therefore allows a direct comparison with the age-adjusted mortality rates of the U.S. All Races population.

Information on Native Hawaiians from the Health Surveillance Program is limited to the numbers of "pure" and "part" Hawaiians. Mortality information is also collected by these two general categories of Native Hawaiians and is presented here for the fol-

lowing categories: (1) all Native Hawaiians, (2) Hawaiians, and (3) Part-Hawaiians.

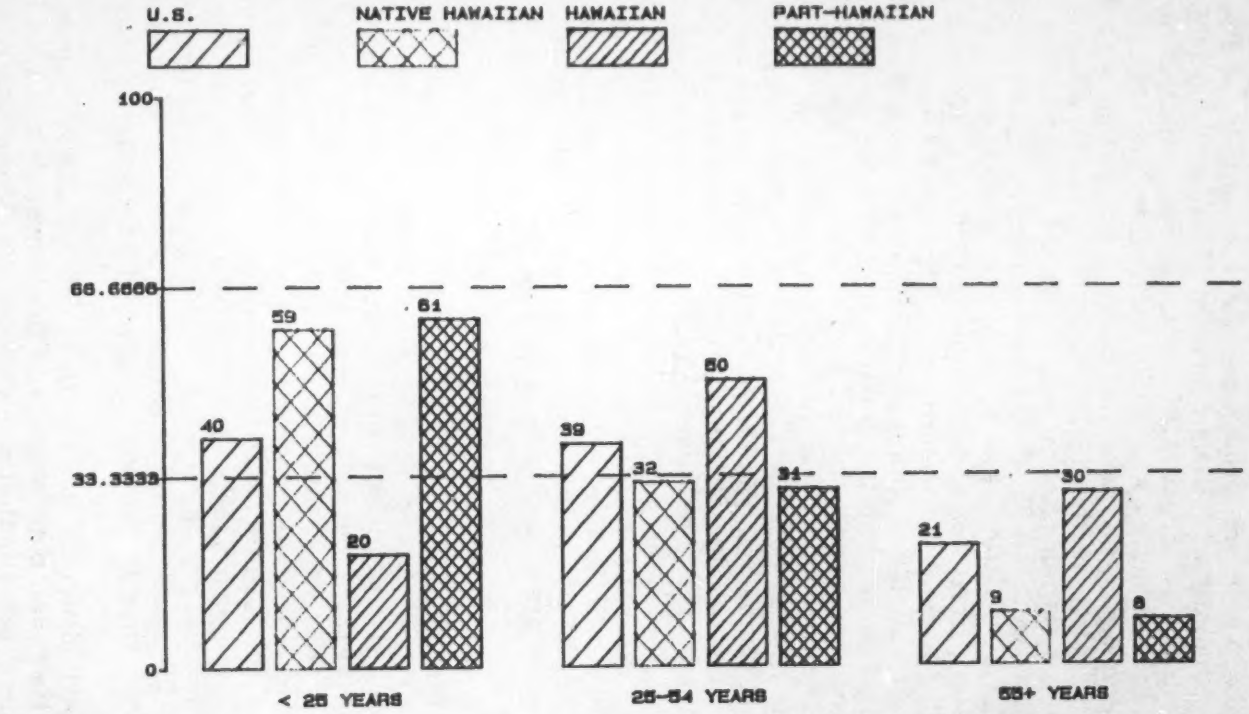
For the population projections, further analysis of the Part-Hawaiian population by their degree of Hawaiian blood (blood quantum) cannot be derived from the usual data sources. However, in 1984, a special survey was conducted on respondents to the Health Surveillance Program who had at least one parent with Hawaiian blood, to detemine the distribution of Native Hawaiians by blood quantum. This information was published by the Office of Hawaiian Affairs in three blood quantum categories: 100%, 50–99%, and less than 50% (10). However, OTA was able to obtain blood quantum data in intervals of 25% from the Office of Hawaiian Affairs, using the original data sources (11). This special survey is the best source of the blood quantum distribution of Native Hawaiians living in Hawaii, but the small sample size led to obvious distortions when the sample was used to estimate the age distribution by blood quantum of all Native Hawaiians living in Hawaii. Therefore, the full 1984 Health Surveillance Program estimates and the 1980 U.S. Cenus data were used to adjust the special survey data in determining the age distribution by Native Hawaiian blood quantum. Finally, the population projections are also dependent on outmarriage rates (marriage of Native Hawaiians to other ethnic groups), fertility rates, the ratio of female births to total births, and age-specific female and male survival rates. The use of these factors in the population projections and the general methodology of the model are described in Appendix B.

CURRENT POPULATION

The number of Native Hawaiians living in Hawaii during 1980 through 1985 averaged 184,841; 8,134 Hawaiians and 176,707 Part-Hawaiians (9). Hawaiians thus comprised less than 5 percent of the Native Hawaiian population, and Part-Hawaiians, more than 95 percent. The large number of Part-Hawaiians relative to the number of Hawaiians means that, when both groups are aggregated under the label of "Native Hawaiians," the resulting characteristics will predominantly reflect the characteristics of the Part-Hawaiian population. (Estimated of the total population of Hawaii during this same period averaged 971,470. The Native Hawaiian population thus comprised 19 percent of the total population in Hawaii.)

The age distributions of the U.S. All Races population, the Native Hawaiian population, and the Hawaiian and Part-Hawaiian populations are summarized in Figure 2. More details of the Hawaiian and Part-Hawaiian populations' age distributions are presented in Table 1.

PERCENT DISTRIBUTION BY AGE CATEGORIES FOR US CIVILIAN POPULATION (JULY 1982) AND NATIVE HAWAIIAN, HAWAIIAN AND PART-HAWAIIAN POPULATIONS*



* (YEARLY AVERAGE FOR 1980-1985)

Source: U.S. Bureau of the Census, Estimates of the Population of the United States, by Age, Sex, and Race: 1980 to 1984; State of Hawaii, Dept. of Health, Research & Statistics Office.

TABLE 1.—AGE-DISTRIBUTION (AND PERCENT OF TOTAL) OF HAWAIIAN AND PART-HAWAIIAN POPULATIONS (1980–85 YEARLY AVERAGES)

Age bracket	Hawaiian		Part-Hawaiian	
	Number	Percent	Number	Percent
0 to 4	221	2.7	24,558	13.9
5 to 14	468	5.8	43,924	24.9
15 to 24	941	11.6	39,516	22.4
25 to 34	1,160	14,3	27,222	15.4
35 to 44	1,401	17.2	16,401	9.3
45 to 54	1,486	18.3	11,757	6.7
55 to 64	1,150	14.1	7,606	4.3
65 to 74	811	10.0	4,030	2.3
75 and above	496	6.1	1.693	1.0
Totals	8,134	[1] 100.1	176,707	100.2

[1] Total percentages do not equal 100.0 because of rounding.

Source: Stae of Hawaii, Department of Health, Health Surveillance Program.

When compared to the U.S. All Races population, the Hawaiian population is significantly older, and the Part-Hawaiian population is significantly younger. Forty percent of the U.S. All Races population was under 25 years of age, compared to 59 percent of the Part-Hawaiian population and only 20 percent of the Hawaiian population. At the other end of the age spectrum, 21 percent of the U.S. All Races population was 55 years or older, compared to 30 percent of the Hawaiian population and only 8 percent of the Part-Hawaiian population.

The principal reason for this age disparity between the Hawaiian and Part-Hawaiian populations is the small size of the Hawaiian population and the diminishing chances that Hawaiians will marry other Hawaiians. In recent years, marriages between Hawaiians and other ethnic groups in Hawaii (including Part-Hawaiians) have hovered around 90 percent of all marriages, while the "outmarriage" rate for Part-Hawaiians has been between 50 to 60 percent (8).

NATIVE HAWAIIAN MORTALITY

The leading causes of death among Native Hawaiians and comparisons of their mortality rates with the U.S. All Races rates are presented in Table 2. The two leading and dominant causes of death for both groups were identical; diseases of the heart and malignant neoplasms (cancers). The overall death rate, however, was 34 percent higher for Native Hawaiians, with higher rates for diseases of the heart (44 percent greater), cancer (39 percent greater), cerebrovascular diseases (31 percent greater), and diabetes mellitus (222 percent greater). Of the five leading causes of death among Native Hawaiians, only deaths from "accidents and adverse effects" had a lower rate than the U.S. All Races population (8 percent lower). The other comparisons are less reliable because of the small number of yearly deaths among the Native Hawaiian population.

TABLE 2.—NATIVE HAWAIIANS (BOTH SEXES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	888	739.2	552.2	1.34
1. Diseases of the heart	297	273.0	189.7	1.44
2. Malignant neoplasms	204	183.9	132.6	1.39
3. Accidents & adverse effects	55	33.0	36.0	.92
4. Cerebrovascular disease	50	46.1	35.1	1.31
5. Diabetes mellitus	32	29.0	9.8	3.22
6. Certain conditions originating in the perinatal period	28	8.9	8.5	1.05
7. Pneumonia & influenza	21	18.1	11.4	1.59
8. Congenital anomalies	17	6.1	5.6	1.09
9. Suicide	17	9.4	11.5	.82
10. Other diseases of arteries, arterioles, and capillaries	11	9.6	5.3	1.81
11. All other infectious and parasitic diseases	10	8.3	1.6	5.19
12. Homicide and legal intervention	10	6.3	9.2	.68
13. Chronic liver disease and cirrhosis	9	7.7	10.4	.74
14. Chronic obstructive pulmonary disease and allied conditions	8	6.5	16.8	.39
15. Nephritis, nephrotic syndrome and nephrosis	6	5.5	4.6	1.20
All other conditions	113	87.8	64.5	1.36

[1] Male and female totals calculated separately and may not equal for both sexes
[2] Subtotals may not equal totals because of rounding.

Source: State of Hawaii, Dept. of Health, Research & Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984: "Advance Report for Final Mortality Statistics, 1983, "Monthly Vital Statistics Report 34(6): Supp. Sept. 26, 1985.

Similar information on the Native Hawaiian population by sex is presented in Tables 3 and 4. The U.S. All Races male population had a higher death rate than U.S. All Races females, which is also reflected in the Native Hawaiian population (compare Tables 3 and 4). However, when comparisons are made by sex between Native Hawaiians and U.S. All Races, Native Hawaiian females are relatively worse off than Native Hawaiian males. Native Hawaiian males had a death rate 19 percent higher than U.S. All Races males (Table 3), whereas Native Hawaiian females had a death rate 51 percent higher than U.S. All Races females (Table 4). This pattern was also reflected in the death rates for specific causes of death, with the exception of suicides, for which Native Hawaiian males (0.84) had a slightly higher relative rate than females (0.66) when compared to their U.S. All Races counterparts, although both Native Hawaiian males and females had lower death rates than U.S. All Races males and females.

TABLE 3.—NATIVE HAWAIIANS (MALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (MALES), BY AGE–ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	503	870.9	729.2	1.19
1. Diseases of the heart	169	328.1	262.4	1.25
2. Malignant neoplasms	111	210.0	164.6	1.28
3. Accidents and adverse effects	40	48.1	54.1	0.89

TABLE 3.—NATIVE HAWAIIANS (MALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (MALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)—Continued

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
4. Cerebrovascular diseases	24	46.7	38.5	1.21
5. Diabetes mellitus	15	28.0	9.9	2.83
6. Certain conditions originating in the perinatal period	14	9.0	9.4	0.96
7. Suicide	14	15.3	18.3	0.84
8. Pneumonia and influenza	12	22.6	15.9	1.42
9. Congenital anomalies	9	5.9	5.9	1.00
10. Homicide and legal intervention	7	9.1	14.5	0.63
11. Other diseases of arteries, arterioles, and capillaries	6	11.1	8.4	1.32
12. Chronic liver disease and cirrhosis	6	10.5	14.6	0.72
13. All other infectious and parasitic diseases	5	9.7	2.0	4.85
14. Chronic obstructive pulmonary diseases and allied conditions	4	6.6	26.3	0.25
15. Atherosclerosis	3	6.3	5.5	1.15
All other conditions	64	103.5	79.3	1.31

[1] Male and female totals calculated separately and may not equal total for both sexes.
[2] Subtotals may not equal totals because of rounding.

Source: State of Hawaii, Dept. of Health, Research & Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

TABLE 4.—NATIVE HAWAIIANS (FEMALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. RACES (FEMALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGE)

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	388	622.3	411.4	1.51
1. Diseases of the heart	128	222.9	132.4	1.68
2. Malignant neoplasms	93	160.3	109.7	1.46
3. Cerebrovascular diseases	27	46.2	32.5	1.42
4. Diabetes mellitus	17	29.7	9.6	3.09
5. Accidents and adverse effects	15	18.4	18.8	.98
6. Certain conditions originating in the perinatal period	14	8.7	7.4	1.18
7. Pneumonia and influenza	9	14.4	8.4	1.71
7. Congenital anomalies	9	6.5	5.3	1.23
9. All other infectious and parasitic diseases	5	7.4	1.3	5.69
9. Other diseases of arteries, arterioles, and capillaries	5	8.1	3.1	2.61
11. Nephritis, nephrotic syndrome, and nephrosis	4	7.2	3.8	1.89
11. Chronic obstructive pulmonary disease and allied conditions	4	6.1	10.4	.59
13. Suicide	3	3.5	5.3	.66
13. Homicide and legal intervention	3	3.4	4.0	.85
13. Atherosclerosis	3	4.5	4.2	1.07
13. Hypertension with or without renal disease	3	4.2	1.6	2.63
All other conditions	46	70.8	53.7	1.32

[1] Male and female totals calculated separately and may not equal total for both sexes.
[2] Subtotals may not equal totals because of rounding.

Source: State of Hawaii, Dept. of Health, Research & Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

Hawaiian mortality

Mortality data on all Native Hawaiians principally reflect the data on Part-Hawaiians and mask the data on Hawaiians. Because of the small numbers of Hawaiians, only the four leading causes of

death averaged more than 10 deaths per year. Comparisons of Hawaiian mortality rates with those of their U.S. All Races counterparts are presented in Tables 5, 6, and 7. Comparing the 15 leading causes of death among Native Hawaiians (Table 2) with the leading causes of death among Hawaiians (Table 5), "congential anomalies" and "certain conditions originating in the perinatal period" are replaced by "atherosclerosis" and "hypertension with or without renal disease," which reflects the older Hawaiian population. More importantly, Hawaiians died at a rate 146 percent higher than the U.S. All Races population (Table 5), compared to an excess death rate for all Native Hawaiians of 34 percent (Table 2). Of the four leading causes of death, Hawaiians when compared to U.S. All Races had rates 177 percent higher for diseases of the heart, 126 percent higher for cancers, 145 percent higher for cerebrovascular disease, and 588 percent higher for diabetes mellitus.

TABLE 5.—HAWAIIANS (BOTH SEXES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES, BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	213	1,357.5	552.2	2.46
1. Diseases of the heart	87	525.1	189.7	2.77
2. Malignant neoplasms	48	299.1	132.6	2.26
3. Cerebrovascular diseases	16	86.1	35.1	2.45
4. Diabetes mellitus	11	67.4	9.8	6.88
5. Accidents and adverse effects	7	76.8	36.0	2.13
5. Pneumonia and influenza	7	35.6	11.4	3.12
7. All other infectious and parasitic diseases	3	15.0	1.6	9.38
8. Atherosclerosis	2	11.7	4.7	2.45
8. Chronic obstructive pulmonary diseases and allied conditions	2	15.4	16.8	.92
8. Other diseases of arteries, arterioles, and capillaries	2	12.1	5.3	2.28
8. Nephritis, nephrotic syndrome, and nephrosis	2	10.2	4.6	2.22
8. Homicide and legal intervention	2	19.4	9.2	2.11
8. Hypertension with or without renal disease	2	9.2	1.8	5.11
14. Chronic liver disease and cirrhosis	1	7.9	10.4	.76
14. Suicide	1	11.8	11.5	1.03
All other conditions	20	154.7	71.1	2.18

[1] Male and female totals calculated separately and may not equal total for both sexs.
[2] Subtotals may not equal totals because of rounding.

Source: State of Hawaii, Dept. of Health, Research & Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept 26, 1985.

When death rates are compared for males and females, we find that Hawaiian males died at a rate 135 percent higher than U.S. All Races males (Table 6), and Hawaiian females died at a rate 163 percent higher than U.S. All Races females (Table 7). As in the case of the overall Native Hawaiian population, Hawaiian females were relatively worse off than Hawaiian males when compared to their U.S. all races counterparts, and this comparison holds generally for specifically causes of death (compare Tables 6 and 7).

TABLE 6.—HAWAIIANS (MALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (MALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	124	1,711.1	729.2	2.35
1. Diseases of the heart	52	700.5	262.4	2.67
2. Malignant neuplasms	28	363.8	164.6	2.21
3. Cerebrovascular diseases	9	108.8	38.5	2.83
4. Accidents and adverse effects	5	110.9	54.1	2.05
4. Diabetes mellitus	5	63.2	9.9	6.38
6. Pneumonia and influenza	4	40.3	15.9	2.53
7. Atherosclerosis	1	14.8	5.5	2.69
7. Chronic obstructive pulmonary diseases and allied conditions	1	18.1	26.3	0.69
7. All other infectious and parasitic diseases	1	12.6	2.0	6.30
7. Other diseases of arteries, arterioles, and capillaries	1	14.5	8.4	1.73
7. Homicide and legal intervention	1	29.1	14.5	2.01
7. Suicide	1	25.7	18.3	1.40
7. Chronic liver disease and cirrhosis	1	12.4	14.6	0.85
7. Hypertension with or without renal disease	1	9.0	2.2	4.09
7. Nephritis, nephrotic syndrome, and nephrosis	1	7.5	5.8	1.29
All other conditions	12	179.9	86.9	2.07

TABLE 7—HAWAIIANS (FEMALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (FEMALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980-85 (YEARLY AVERAGES)

Rank and cause of death	No. of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	90	1,081.4	411.4	2.63
1. Diseases of the heart	35	373.6	132.4	2.82
2. Malignant neoplasms	20	238.5	109.7	2.17
3. Cerebrovascular diseases	7	69.0	32.5	2.12
4. Diabetes mellitus	6	70.1	9.6	7.30
5. Pneumonia and influenza	3	32.8	8.4	3.90
6. Accidents and adverse effects	2	55.5	18.8	2.95
6. All other infectious and parasitic diseases	2	19.2	1.3	14.77
8. Nephritis, nephrotic syndrome, and nephrosis	1	12.8	3.8	3.37
8. Atherosclerosis	1	10.6	4.2	2.52
8. Hypertension with or without renal disease	1	9.9	1.6	6.19
8. Other diseases of arteries, arterioles, and capillaries	1	10.5	3.1	3.39
8. Chronic obstructive pulmonary diseases and allied conditions	1	14.9	10.4	1.43
8. Homicide and legal intervention	1	10.6	4.0	2.65
14. (remaining causes average less than 1 case per year) All other conditions	9	153.4	72.7	2.11

[1] Male and female totals calculated separately and may not equal total for both sexes.
[2] Subtotals may not equal totals because of rounding.
Source: State of Hawaii, Dept. of Health, Research & Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982, "Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983, "Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

Part-Hawaiian mortality

Comparisons of the mortality rates for Part-Hawaiians and U.S. All Races are presented in Tables 8, 9, and 10. The young age of the Part-Hawaiian population is reflected in the high ranking of

perinatal conditions (#5) and congenital anomalies (#7) as leading causes of death.

Part-Hawaiians died at a rate higher than U.S. All Races, but only 17 percent higher (Table 8). As in the case of the Hawaiian population, diseases of the heart (21 percent greater), cancer (23 percent greater), and diabetes mellitus (171 percent greater) accounted for much of this difference.

TABLE 8.—PART HAWAIIANS (BOTH SEXES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES, BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	673	645.2	552.2	1.17
1. Diseases of the heart	211	230.1	189.7	1.21
2. Malignant neoplasms	156	162.8	132.6	1.23
3. Accidents and adverse effects	48	30.1	36.0	.84
4. Cerebrovascular diseases	35	38.3	35.1	1.09
5. Certain conditions orginating in the perinatal period	27	8.9	8.5	1.05
6. Diabetes mellitus	20	26.6	9.8	2.71
7. Congenital anomalies	17	6.2	5.6	1.11
8. Suicide	16	9.1	11.5	.79
9. Pneumonia and influenza	14	14.7	11.4	1.29
10. Homicide and legal intervention	8	5.6	9.2	.61
10. Other diseases of arteries, arterioles, and capillaries	8	9.2	5.3	1.74
10. Chronic liver disease and cirrhosis	8	7.9	10.4	.76
13. All other infectious and parasitic diseases	7	7.9	1.6	4.94
14. Chronic obstructive pulmonary diseases and allied conditions	6	5.4	16.8	.32
15. Nephritis, nephrotic syndrome, and nephrosis	4	4.4	4.6	.96
All other conditions	88	78.0	64.2	1.21

[1] Male and female totals calculated separately and may not equal total for both sex.
[2] Subtotals may not equal totals because of rounding.

Source: State of Hawaii, Dept. of Health, Research & Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

When comparisons are made by sex, Part-Hawaiian males turn out to have had death rates comparable to U.S. All Races males (Table 9). Part-Hawaiian females had death rates 34 percent higher than U.S. All Races females (Table 10), with 48 percent higher rates for diseases of the heart, 33 percent higher rates for cancer, 29 percent higher rates for cerebrovascular diseases, and 127 percent higher rates for diabetes mellitus.

TABLE 9.—PART-HAWAIIANS (MALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL (MALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	380	732.1	729.2	1.00
1. Diseases of the heart	118	267.8	262.4	1.02
2. Malignant neoplasms	83	181.2	164.6	1.10
3. Accidents and adverse effects	36	44.4	54.1	.82
4. Cerebrovascular diseases	15	34.4	38./5	.89
5. Certain conditions originating in the perinatal period	14	9.0	9.4	.96
6. Suicide	13	14.5	18.3	.79

TABLE 9.—PART-HAWAIIANS (MALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL (MALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)—Continued

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
7. Diabetes mellitus	10	22.6	9.9	2.28
8. Congenital anomalies	9	6.0	5.9	1.02
9. Pneumonia and influenza	8	18.6	15.9	1.17
10. Homicide and legal intervention	6	8.2	14.5	.57
11. Chronic liver disease and cirrhosis	5	10.4	14.6	.71
12. Other diseases of arteries, arterioles, and capillaries	5	10.3	8.4	1.23
13. All other infectious and parasitic diseases	4	8.4	2.0	4.20
14. Chronic obstructive pulmonary diseases and allied conditions	3	4.5	26.3	.17
15. Atherosclerosis	2	4.3	5.5	.78
All other conditions	49	87.5	79.6	1.10

[1] Male and female totals calculated separately and may not equal total for both sexes.
[2] Subtotals may not equal totals because of rounding.

Source: State of Hawaii, Dept. of Health, Research & Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

TABLE 10.—PART-HAWAIIANS (FEMALES): LEADING CAUSES OF DEATH AND COMPARISON WITH U.S. ALL RACES (FEMALES), BY AGE-ADJUSTED DEATHS PER 100,000 POPULATION, 1980–85 (YEARLY AVERAGES)

Rank and cause of death	Number of deaths [1]	Age-adjusted death rate [2]		
		Hawaiian	United States	Ratio
All causes	300	553.0	411.4	1.34
1. Diseases of the heart	93	196.0	132.4	1.48
2. Malignant neoplasms	73	146.2	109.7	1.33
3. Cerebrovascular diseases	20	42.0	32.5	1.29
4. Certain conditions originating in the perinatal period	14	8.8	7.4	1.19
5. Accidents and adverse effects	13	16.0	18.8	.85
6. Diabetes mellitus	11	21.8	9.6	2.27
7. Congenital anomalies	9	6.5	5.3	1.23
8. Pneumonia and influenza	6	11.4	8.4	1.36
9. Other diseases of arteries, arterioles, and capillaries	4	7.8	3.1	2.52
9. Chronic obstructive pulmonary diseases and allied conditions	4	6.0	10.4	.58
11. All other infectious and parasitic diseases	3	5.4	1.3	4.15
11. Suicide	3	3.8	5.3	.72
11. Nephritis, nephrotic syndrome, and nephrosis	3	6.0	3.8	1.58
11. Chronic liver disease and cirrhosis	3	5.4	6.7	.81
11. Homicide and legal intervention	3	2.4	4.0	.40
All other conditions	38	67.6	52.8	1.28

[1] Male and female totals calculated separately and may not equal total for both sexes.
[2] Subtotals may not equal totals because of rounding.

Sources: State of Hawaii, Dept. of Health, Research & Statistics Office and Health Surveillance Program; National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supp., Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supp., Sept. 26, 1985.

TABLE 11.—COMPARISON OF AGE-ADJUSTED DEATH RATES PER 100,000 POPULATION FOR HAWAIIANS AND PART-HAWAIIANS (BOTH SEXES) BY SELECTED LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)

Cause of death	Age-Adjusted Death Rate [1]		
	Hawaiians	Part-Hawaiians	Ratio
All causes	1,357.5	645.2	2.10
Diseases of the heart	525.1	230.1	2.28
Malignant neoplasms	299.1	162.8	1.84
Diabetes mellitus	67.4	26.6	2.53
Cerebrovascular diseases	86.1	38.3	2.25
Other diseases of arteries, arterioles, and capillaries	12.1	9.2	1.32
Nephritis, nephrotic syndrome, and nephrosis	10.2	4.4	2.32
Accidents and adverse effects	76.8	30.1	2.55
Suicide	11.8	9.1	1.30
Homicide and legal intervention	19.4	5.6	3.46
Pneumonia and influenza	35.6	14.7	2.42
All other infectious and parasitic diseases	15.0	7.9	1.90
Chronic obstructive pulmonary diseases and allied conditions	15.4	5.4	2.85
Chronic liver disease and cirrhosis	7.9	7.9	1.00

[1] Subtotals may not equal totals because of rounding.

Source: State of Hawaii, Dept. of Health, Research and Statistics Office and Health Surveillance Program.

TABLE A–1.—PERCENT OF TOTAL DEATHS AND AGE-ADJUSTED DEATH RATES FOR THE 15 LEADING CAUSES OF DEATH, UNITED STATES, 1982–83

Rank and cause of death	Percent of total deaths [1]	Age-adjusted death rate [1]
All causes	100.0	552.2
1. Diseases of the heart	38.3	189.7
2. Malignant neoplasms	22.0	132.6
3. Cerebrovascular diseases	7.9	35.1
4. Accidents and adverse effects	4.7	36.0
5. Chronic obstructive pulmonary diseases and allied conditions	3.2	16.8
6. Pneumonia and influenza	2.7	11.4
7. Diabetes mellitus	1.8	9.8
8. Suicide	1.4	11.5
9. Chronic liver disease and cirrhosis	1.4	10.4
10. Atherosclerosis	1.4	4.7
11. Homicide and legal intervention	1.1	9.2
12. Certain conditions originating in the perinatal period	1.1	8.5
13. Nephritis, nephrotic syndrome, and nephrosis	0.9	4.6
14. Congenital anomalies	0.7	5.6
14. Septicemia	0.7	3.2
All other condtions	11.4	63.7

[1] Subtotals may not equal totals because of rounding.

Source: National Center for Health Statistics, "Advance Report for Final Mortality Statistics, 1982," Monthly Vital Statistics Report 33(9): Supplement, Dec. 20, 1984; "Advance Report for Final Mortality Statistics, 1983," Monthly Vital Statistics Report 34(6): Supplement, Sept. 26, 1985.

TABLE A–2.—NATIVE HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—BOTH SEXES

Cause of death	Number of deaths	Percent of total [1]
1. Diseases of the heart	297	33.4
2. Malignant neoplasms	204	23.0

TABLE A–2.—NATIVE HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—BOTH SEXES—Continued

Cause of death	Number of deaths	Percent of total [1]
3. Accidents and adverse effects	55	6.2
4. Cerebrovascular diseases	50	5.6
5. Diabetes mellitus	32	3.6
6. Certain conditions originating in the perinatal period	28	3.2
7. Pneumonia and influenza	21	2.4
8. Congenital anomalies	17	1.9
9. Suicide	17	1.9
10. Other diseases of arteries, arterioles, and capillaries	11	1.2
11. All other infectious and parasitic diseases	10	1.1
11. Homicide and legal intervention	10	1.1
13. Chronic liver disease and cirrhosis	9	1.0
14. Chronic obstructive pulmonary diseases and allied conditions	8	0.9
15. Nephritis, nephrotic syndrome, and nephrosis	6	0.7
All other conditions	113	12.7
Total	[2] 888	99.0

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Dept. of Health, Research and Statistics Office.

TABLE A–3.—NATIVE HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—MALES

Cause of death	Number of deaths	Percent of total [1]
1. Diseases of the heart	169	33.6
2. Malignant neoplasms	111	22.1
3. Accidents and adverse effects	40	8.0
4. Cerebrovascular diseases	24	4.8
5. Diabetes mellitus	15	3.0
6. Certain conditions originating in the perinatal period	14	2.8
6. Suicide	14	2.8
8. Pneumonia and influenza	12	2.4
9. Congenital anomalies	9	1.8
10. Homicide and legal intervention	7	1.4
11. Other diseases of arteries, arterioles, and capillaries	6	1.2
11. Chronic liver disease and cirrhosis	6	1.2
13. All other infectious and parasitic diseases	5	1.0
14. Chronic obstructive pulmonary diseases and allied conditions	4	.8
15. Atherosclerosis	3	.6
All other conditions	64	12.7
Total	[2] 503	100.2

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.

Source: State of Hawaii, Dept. of Health, Research and Statistics Office.

TABLE A–4.—NATIVE HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—FEMALES

Cause of death	Number of deaths	Percent of total [1]
1. Diseases of the heart	128	33.0
2. Malignant neoplasms	93	24.0
3. Cerebrovascular diseases	27	7.0
4. Diabetes mellitus	17	4.4

TABLE A–4.—NATIVE HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—FEMALES—Continued

Cause of death	Number of deaths	Percent of total [1]
5. Accidents and adverse effects	15	3.9
6. Certain conditions originating in the perinatal period	14	3.6
7. Pneumonia and influenza	9	2.3
7. Congenital anomalies	9	2.3
9. All other infectious and parasitic diseases	5	1.3
9. Other diseases of arteries, arterioles, and capillaries	5	1.3
11. Nephritis, nephrotic syndrome and nephrosis	4	1.0
11. Chronic obstructive pulmonary diseases and allied conditions	4	1.0
13. Suicide	3	.8
13. Homicide and legal interevention	3	.8
13. Atherosclerosis	3	.8
13. Hypertension with or without renal disease	3	.8
All other conditions	46	11.9
Total	[2] 388	100.2

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.
Source: State of Hawaii, Dept. of Health, Research and Statistics Office.

TABLE A–5.—HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—BOTH SEXES

Cause of death	Number of deaths	Percent of total [1]
1. Disease of the heart	87	40.8
2. Malignant neoplasms	48	22.5
3. Cerebrovascular disease	16	7.5
4. Diabetes mellitus	11	5.2
5. Accidents and adverse effects	7	3.3
5. Pneumonia and influenza	7	3.3
7. All other infectious and parasitic diseases	3	1.4
8. Atherosclerosis	2	.9
8. Chronic obstructive pulmonary diseases and allied conditions	2	.9
8. Other diseases of arteries, arterioles, and capillaries	2	.9
8. Nephritis, nephrotic syndrome, and nephrosis	2	.9
8. Homicide and legal intervention	2	.9
8. Hypertension with or without renal disease	2	.9
14. Chronic liver disease and cirrhosis	1	.5
14. Suicide	1	.5
All other conditions	20	9.4
Total	[2] 213	99.8

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.
Source: State of Hawaii, Dept. of Research and Statistics Office.

TABLE A–6.—HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—MALES

Cause of death	Number of deaths	Percent of total [1]
1. Diseases of the heart	52	41.9
2. Malignant neoplasms	28	22.6
3. Cerebrovascular diseases	9	7.3
4. Accidents and adverse effects	5	4.0
4. Diabetes mellitus	5	4.0
6. Pneumonia and influenza	4	3.2
7. Atherosclerosis	1	0.8

TABLE A–6—HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—MALES—Continued

Cause of death	Number of deaths	Percent of total [1]
7. Chronic obstructive pulmonary diseases and allied conditions	1	0.8
7. All other infectious and parasitic diseases	1	0.8
7. Other diseases of arteries, arterioles, and capillaries	1	0.8
7. Homicide and legal intervention	1	0.8
7. Suicide	1	0.8
7. Chronic liver disease and cirrhosis	1	0.8
7. Hypertension with or without renal disease	1	0.8
7. Nephritis, nephrotic syndrome and nephrosis	1	0.8
All other conditions	12	9.7
Total	[2] 124	99.9

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.
Source: State of Hawaii, Dept. of Health, Research and Statistics Office.

TABLE A–7.—HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—FEMALES

Cause of death	Number of deaths	Percent of total [1]
1. Diseases of the heart	35	38.9
2. Malignant neoplasms	20	22.2
3. Cerebrovascular diseases	7	7.8
4. Diabetes mellitus	6	6.7
5. Pneumonia and influenza	3	3.3
6. Accidents and adverse effects	2	2.2
6. All other infectious and parasitic diseases	2	2.2
8. Nephritis, nephrotic syndrome and nephrosis	1	1.1
8. Atherosclerosis	1	1.1
8. Hypertension with or without renal disease	1	1.1
8. Other diseases of arteries, arterioles, and capillaries	1	1.1
8. Chronic obstructive pulmonary diseases and allied conditions	1	1.1
8. Homicide and legal intervention	1	1.1
14. (remaining causes average less than 1 case per year)		
All other conditions	9	10.0
Total	[2] 90	99.9

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.
Source: State of Hawaii, Dept. of Health, Research and Statistics Office.

TABLE A–8.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—BOTH SEXES

Cause of death	Number of deaths	Percent of total [1]
1. Diseases of the heart	211	31.4
2. Malignant neoplasms	156	23.2
3. Accidents and adverse effects	48	7.1
4. Cerebrovascular diseases	35	5.2
5. Certain conditions originating in the perinatal period	27	4.0
6. Diabetes mellitus	20	3.0
7. Congenital anomalies	17	2.5
8. Suicide	16	2.4
9. Pneumonia and influenza	14	2.1
10. Homicide and legal intervention	8	1.2
10. Other diseases of arteries, arterioles, and capillaries	8	1.2
10. Chronic liver disease and cirrhosis	8	1.2

TABLE A–8.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—BOTH SEXES—Continued

Cause of death	Number of deaths	Percent of total [1]
13. All other infectious and parasitic diseases	7	1.0
14. Chronic obstructive pulmonary diseases and allied conditions	6	.9
15. Nephritis, nephrotic syndrome, and nephrosis	4	.6
All other conditions	88	13.1
Total	[2] 673	100.0

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.
Source: State of Hawaii, Dept. of Health, Research & Statistics Office.

TABLE A–9.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—MALES

Cause of death	Number of deaths	Percent of total [1]
1. Diseases of the heart	118	31.1
2. Malignant neoplasms	83	21.8
3. Accidents and adverse effects	36	9.5
4. Gerebrovascular diseases	15	3.9
5. Certain conditions originating in the perinatal period	14	3.7
6. Suicide	13	3.4
7. Diabetes mellitus	10	2.6
8. Congenital anomalies	9	2.4
9. Pneumonia and influenza	8	2.1
10. Homicide and legal intervention	6	1.6
11. Chronic liver disease and cirrhosis	5	1.3
11. Other diseases of arteries, arterioles, and capillaries	5	1.3
13. All other infectious and parasitic diseases	4	1.0
14. Chronic obstructive pulmonary disease and allied conditions	3	.8
15. Atherosclerosis	2	.5
All other conditions	49	12.9
Total	[2] 380	99.9

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.
Source: State of Hawaii, Dept. of Health, Research and Statistics Offices.

TABLE A–10.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—FEMALES

Cause of death	Number of deaths	Percent of total [1]
1. Diseases of the heart	93	31.0
2. Malignant neoplasms	73	24.3
3. Cerebrovascular diseases	20	6.7
4. Certain conditions originating in the perinatal period	14	4.7
5. Accidents and adverse effects	13	4.3
6. Diabetes mellitus	11	3.7
7. Congenital anomalies	9	3.0
8. Pneumonia and influenza	6	2.0
9. Other diseases of arteries, arterioles, and capillaries	4	1.3
9. Chronic obstructive pulmonary diseases and allied conditions	4	1.3
11. All other infectious and parasitic diseases	3	1.0
11. Suicide	3	1.0
11. Nephritis, nephrotic syndrome and nephrosis	3	1.0
11. Chronic liver disease and cirrhosis	3	1.0
11. Homicide and legal intervention	3	1.0

TABLE A–10.—PART-HAWAIIANS: LEADING CAUSES OF DEATH, 1980–85 (YEARLY AVERAGES)—FEMALES—Continued

Cause of death	Number of deaths	Percent of total [1]
All other conditions	38	12.7
Total	[2] 300	100.0

[1] Subtotals may not equal total because of rounding.
[2] Male and female totals calculated separately and may not equal total for both sexes.
Source: State of Hawaii, Dept. of Health, Research and Statistics Office.

There is thus little doubt that the health status of Native Hawaiians is far below that of other U.S. population groups, and that in a number of areas, the evidence in compelling that Native Hawaiians constitute a population group for whom the mortality rate associated with certain diseases exceed that for other U.S. populations in alarming proportions.

Native Hawaiians premise the high mortality rates and the incidence of disease that far exceed that of other populations in the United States upon the breakdown of the Hawaiian culture and belief systems, including traditional healing practices, that was brought about by western settlement, and the influx of western diseases to which the native people of the Hawaiian Islands lacked immune systems. Further, Native Hawaiians predicate the high incidence of mental illness and emotional disorders in the Native Hawaiian population as evidence of the cultural isolation and alienation of the native peoples, in a statewide population in which they now constitute only 20 percent. Settlement from both the east and the west not only brought new diseases which decimated the Native Hawaiian population, but which devalued the customs and traditions of Native Hawaiians, and which eventually resulted in Native Hawaiians being prohibited from speaking their native tongue in school, and in many instances, at all.

The concepts embodied in S. 136 are the result of the Committee's work with Native Hawaiian health care professionals and others who are dedicated to improving the health status of Native Hawaiians. It is based on the beliefs of those with whom the Committee has consulted, that to insure that Native Hawaiians are able to achieve the healthful harmony of the self (body, mind and spirit) or *lokahi,* with others and all of nature, and to assure that Native Hawaiians are able to function effectively as citizens and leaders in their own homeland, there must be a restoration of cultural traditions, an integration of traditional healing methods in the health care delivery system, and a collective effort to restore to the Native Hawaiian, a sense of self esteem and self worth, both for his or her culture, as well as for the individual.

A group of Native Hawaiian health care professionals known as *E Ola Mau,* have proposed that this effort begin with the development of a health care master plan, based on a bio-psychosocio-cultural-political model that would be aimed at identifying significant events and factors related to specific health care needs and issues. *E Ola Mau* proposes that this master plans be implemented at every societal level (individual, household, community, county and state) in the Hawaiian Islands, and it is their goal to have this

Native Hawaiian way of dealing with health, eventually become an institutional part of the state's health policy for both Native Hawaiian and Non-Hawaiians.

After much debate and careful consideration in the Native Hawaiian community and amongst those concerned with the health status of Native Hawaiians, a consensus was reached that *Papa Ola Lokahi,* the Native Hawaiian Health Board, should be the mechanism through which a Native Hawaiian health care system can be developed, coordinated, administered, monitored, and continually revised to meet the changing health care needs of the Native Hawaiian population. *Papa Ola Lokahi* is proposed to be formed of five organizations: (1) the Office of Hawaiian Affairs, an agency mandated in the Constitution of the State of Hawaii to assure the well-being the interests of Native Hawaiians; (2) E Ola Mau, a nonprofit organization of Native Hawaiian professionals dedicated to insuring that Native Hawaiians achieve a healthful harmony of self (body, mind and spirit) with others and all of nature, and become productive citizens and leaders in their homeland; (3) Alu Like, a Federally-funded Native Hawaiian agency that promotes vocational training and the founding of community-based organizations that promote health, education and economic development for Native Hawaiians; (4) the University of Hawaii John A. Burns School of Medicine, which has become the institutional leader in affirmative action programs that train Native Hawaiian physicians, is involved in cross-cultural and clinical training and research, and set the quality and standard of health care in the state's medical community; and (5) the newly established Office of Hawaiian Health within the State Department of Health.

Papa Ola Lokahi, the Native Hawaiian Health Board, would assume the primary responsibility of overseeing the development of a Native Hawaiian Comprehensive Health Care Master Plan, and would be the entity responsible for certifying to the Secretary the qualifications and capabilities of Native Hawaiian organizations that petition the Secretary to carry out, pursuant to contracts with the Secretary, the provisions of the Act.

Papa Ola Lokahi, the Native Hawaiian Health Board, is authorized to—

(1) designate a chairman and vice-chairman from among its member organizations and such other officers as may be deemed necessary to carry out its responsibilities under the Act;

(2) adopt bylaws and such other internal regulations or procedures as may be deemed necessary to carry out its responsibilities under the Act;

(3) certify to the Secretary that a Native Hawaiian organizaton meets the definition of "Native Hawaiian organization" as set forth in the Act;

(4) certify to the Secretary that a Native Hawaiian organization has the qualifications and capacity to provide the services or perform contract requirements pursuant to a contract with the Secretary;

(5) oversee the development of a comprehensive Native Hawaiian health care master plan;

(6) assure the conduct of health status and health care needs assessments by Native Hawaiian Healing Centers in Native Hawaiian communities desiring to participate in Native Hawaiian Healing Centers; and

(7) coordinate the activities and functions of all Native Hawaiian Healing Centers.

S. 136 envisions a comprehensive health care system that is community-based, building upon the Native Hawaiian *'ohana* system (The 'ohana system is based upon the fundamental unit of societal interaction for Native Hawaiians in which a family or an organization is led by a *haku,* the recognized leader, whose function is to coordinate and facilitate the expertise and resources of the various households or affiliated organizations in order to accomplish a task or resolve a problem. The households or affiliated organizations are in turn led by *po'o,* the head of the household or designated leader of the organization.) and incorporating traditional healing (*la'au lapa' au*) practices with western medical services to provide a health care system that will be culturally consistent and responsive to the needs of Native Hawaiian communities. Native Hawaiian Healing Centers (NHHC) would be established on each of the islands comprising the State of Hawaii, upon the acceptance of and in consultation with the Native Hawaiian communities on those islands, following the community health center model, and wherever possible, using existing health care facilities and health care providers now serving the Native Hawaiian communities on those islands. These centers would lead and coordinate the development and implementation of a Native Hawaiian health care system, which would include: (1) a research and monitoring staff, state-certified neighborhood counselors, outreach workers and health educators, traditional Native Hawaiian healers, and Native Hawaiian cultural educators; (2) primary health care providers; (3) primarily health care facilities, using existing health care facilities where practicable and acceptable to the local Native Hawaiian community; (4) participation by the State Department of Health Office of Hawaiian Health in the provision of disease prevention and health promotion programs, as well as a multidisciplinary approach to Native Hawaiian health care which would include nursing, dental hygiene, nutrition education, maternal and infant child care education; and (5) other Federal, state, county, community and private organizations and agencies that could offer services which meet the health care needs of their respective communities.

The development of the master plan referenced above would include: (1) working with Native Hawaiian communities which support the establishment of a Native Hawaiian Health Center; (2) conducting a community health needs assessment survey for participating communities; (3) facilitating the development, establishment, and effective functioning of such Centers on the island of O'ahu, Moloka'i Maui, Hawai'i, Lana'i, Kaua'i and Ni'ihau; and (4) coordinating the work of relevant agencies and organizations to provide participating communities with: (a) direct health care services and health education, including maternal and child health care and mental health care; (b) instruction in the Native Hawaiian language, cultural beliefs and traditions with an emphasis on health concepts and practices; (c) training and education of health

care providers and educators and cultural educators in health promotion and disease prevention; (d) basic and applied research and monitoring of Native Hawaiian health care approaches to validate outcomes and create standards of quality care; (e) development of health care services, training and education that would have a Native Hawaiian perspective as its primary focus; (f) development of Native Hawaiian community health counselors, outreach workers, educators, and community health aide training programs; (g) preventive-oriented health care services in medical, dental, nutrition, mental health, and in other designated areas as needs assessments may identify as necessary; (h) data collection related to prevention of diseases and illnesses among Native Hawaiians; (i) medical and general health-related research into the diseases that are most prevalent among Native Hawaiians; (j) mental health research in areas of mental health problems that are most prevalent in the Native Hawaiian population; (k) ongoing health planning for further development of the Native Hawaiian health care systems; and (l) the provision of health care referral services when certain health care services are not available within the Native Hawaiian Healing Center.

Analysis of the Legal Relationship Between the Federal Government and Native Hawaiians*

SUMMARY

The Federal Government has a trust relationship to Native Hawaiians. The relationship is premised on the course of dealings of the United States and its citizens with Native Hawaiians and their government, the explicit recognition of the relationship by the United States Congress in establishing the Native Hawaiian Home Lands Commission, the recognition of the special status of Native Hawaiians in Hawaii Statehood Act, and the recognition by the federal courts of the relationship. While most commentators agree that a trust relationship exists, there is little agreement as to the exact nature of the obligations implicit in the relationship. It is probable that until Native Hawaiian issues are addressed on a comprehensive basis, such as they have been to some extent for many Indians and Alaskan Natives, the extent of the trust relationship for Native Hawaiians will remain unsettled. What is clear, however, is that Congress does possess the authority, pursuant to the Federal-Native Hawaiian relationship to enact legislation that is rationally related to the purposes of the trust relationship—to legislate for the benefit of Native Hawaiians.

THE HAWAIIAN QUESTION

The issue of the nature of the Federal-Hawaiian Native relationship usually occurs in one of two contexts: (1) whether the relationship has been such that Native Hawaiians have a legal and/or moral basis for claims against the United States; or (2) whether the relationship is such that it justifies the provision of federally

*Legal Analysis of the Federal Government's Relationship with Native Hawaiians prepared by Paul Alexander, Attorney at Law.

funded services to Native Hawaiians. The weight of opinion in Hawaii with respect to the issue of claims is definitively affirmative. Although many of the underlying events and legal analysis relating to claims are relevant to the issue of services, this paper only addresses the services issue.

The services question has sometimes been phrased as whether Native Hawaiians are "Indians" for the purposes of the Federal trust relationship, and whether therefore they can be included within any of the various programs that have been developed for Indians. While a number of legal arguments can be constructed to address the question of whether Native Hawaiians are legally the same as Indians [1]; these formulations do not clearly address the underlying issue. When Congress has determined that a trust relationship exists for an "indigenous group" within its political boundaries, Congress has the authority and the power to determine the perimeters of the social service aspect of that relationship. Whether services for Native Hawaiians should be identical to Indian services, provided through the same delivery systems, or different delivery systems, or a mix thereof, become policy issues. Issues that most likely will be influenced by the particular needs being addressed and the determination of the most effective delivery mechanisms that can be utilized to meet those needs. The key question is therefore—is there a identifiable Federal-Native Hawaiian relationship.

In addressing the above question it is helpful to review the Federal-Indian relationship and how it relates to the provision of social services. Much of the relevant law and underlying concepts concerning trust relations were formed to justify land transactions between Indian tribes first with the colonial European powers, then with the colonies, and finally with the United States. There are functional and legal analogies to be drawn between the Indian experience in North America, and the Native Hawaiian experience in dealings with the Western-European colonial powers, the Republic of Hawaii, and the United States. The analogies are striking. What is also striking is the similarity of consequences. Both Indians and Hawaiians were left with a fraction of their original lands, and with severe economic consequences.

SERVICES AND THE FEDERAL-INDIAN RELATIONSHIP

A key concept of the Federal-Indian Relationship is the Federal trust responsibility. Chief Justice John Marshall is two related cases, *Cherokee Nation* v. *Georgia,* 30 U.S (5 Pet.) 1 (1831), and *Worcester* v. *Georgia,* 31 U.S. (6 Pet.) 515 (1832), described Indian tribes as "domestic independent nations" and characterized the relationship of the United States to the Indian tribes as one that "resembles that of a ward to his guardian." The responsibility to deal with Indians was constitutionally assigned to the Federal Govern-

[1] The argument is based on applying considerations set out in Cohen's *Handbook of Federal Indian Law, infra,* n. 8, that "singly or jointly, have been relied upon in reaching the conclusion that a group consitutes a tribe" of Indians. These include the treaties between the U.S. and Hawaii; recognition of Hawaiians as an aboriginal group in various Congressional Acts; collective rights in rights in land under the Hawaiian Homes Commission Act; and recognition of Hawaiian Natives as an aboriginal group by other Native groups. *Contra,* Price v. State of Hawaii, 764 F.2d 623 (9th Cir. 1985) applying recognition criteria to a specific Hawaiian entity.

ment. This responsibility has become universally known as "the trust relationship." It is important to note that the responsibility has never been fully defined. Because a concrete definition of the trust responsibility might fail to take into account changing conditions and changing needs, the relationship can be described but not defined with any exactness. Indian people tend to define the trust as the responsibility that the Federal Government assumes from the operation of International law, the constitution, treaties and practice for the property and the well-being of Indian people.[2] There are both mandatory and permissive aspects of the trust relationship. Because of the Federal-Indian relationship, the U.S. must exercise certain fiduciary standards with respect to Indian property. The existence of the relationship is also the basis for the provision of services that are not necessarily mandatory. The difference between what is a trust right and what is a trust-based service, often the subject of hard fought political and legal battles, is only occasionally a key issue in the actual delivery of services.[3] In what can be labeled the "trust mandated" or trust right situation, the beneficiaries can hold the trustee accountable, either in terms of monetary damages or equitable enforcement. In what can be termed the trust-based situation, Congress can provide distinct services to Indians; services that are insulated from challenge under the equal protection standars of the fourteenth amendment and similar standards incorporated in the fifth amendment to the Constitution.[4] Although Indians may not be able to require the United States to maintain a particualr service or to provide damages for its withdrawal, in the trust-based situation, the existence of the trust does require that the government observe certain due process procedures in the provision of such services that may not be otherwise required of a discretionary social service program.[5]

Indian people tend to assert that many of the social services that are provided, such as health and education, are services mandated by the trust responsibility. The Executive Branch often argues that most Indian services are at best premised on the trust responsibility but are not required (trust-based). It argues that only services associated with trust property are the "true" trust services. Congress which constitutionally has the power to determine the extent of the trust, generally avoids the issue of determining whether any particular service is required by the trust relationship.[6] These issues are only infrequently addressed by the Courts, and when they are, they come up in unique factual situations, so that the issue of what services are trust rights or simply trust based is likely to remain unsettled. However, it is clear under *Morton* v. *Mancari* that in order for the federal government to provide pro-

---

[2] See, e.g. U.S. Congress, American Indian Policy Review Commission, Final report of the American Indian Policy review Commission (Washington, D.C.: U.S. Government Printing Office, 1977).

[3] See White v. Califano, 437 F. Supp. 543 (D.S.D. 1977), *aff'd* 581 F.2d 697 (8th Cir. 1978) and McNabb v. Heckler, N. CU-83-051-GF (D. Mont. 1986).

[4] Morton V. Mancari, 417 U.S. 535 (1974).

[5] See e.g., Fox v. Morton, 505 F.2d 254 (9th Cir. 1974); Vigil v. Andrus 667 f 2d 931 (10th Cir.. 1982); and Wilson v. Watt, 703 F.2d 395 (10th Cir. 1983).

[6] But see, The Indian Health Care Improvement Act findings which state: ". . . health services to maintain and improve health of Indians are consonant with and required by the Federal government's historical and unique relationship with, and result in responsibility to, the American Indian people." 25 U.S.C. sec 1601.

grams to a distinct class of persons—Indians—the government purpose in the program need only to be rationally tied to the United States' trust obligation to such Indians.

There is a third class of services to which Indian tribes and people have access. These generally are services that are created by Congress to meet a defined social need and Indians are included as one of the many beneficiary groups. Although the trust relationship provides a basis for defining Indians as an eligible class in the general legislation, usually along with a determination of need, analytically such programs are neither trust mandated services, nor strictly speaking services based on the trust responsibility.

SERVICES AND THE FEDERAL-NATIVE HAWAIIAN RELATIONSHIP

Unless Congress clearly established that a particular service is a right under the trust relationship, e.g., the Hawaiian Homes Commission Act, the federal services provided to Hawaiian Natives usually fall within the categories of trust-based services or eligible class services.

To date, Congress has legislated for the benefit of Native Hawaiians in the below listed programs:

—Hawaiian Homes Commission Act, 42 Stat. 108 (1921) provides homesteads to Native Hawaiians.

—Leases in Hawaii National Park made available to Native Hawaiians, 16 U.S.C. sec. 396a (1938).

—Native Hawaiians made an eligible class for services under the Administration for Native Americans, P.L. 93–644 (1974).

—Native Hawaiians made an eligible class for services under the Comprehensive Employment Training Act, P.L. 93–203 (1977)

—Native Hawaiians included as a covered class in the Indian Religious Freedom Act, 42 U.S.C. sec. 1966 (1978)

—Native Hawaiians included as a eligible class for services under the National Institute on Drug Abuse, 21 U.S.C. sec. 1177(d) (1980).

—A Native Hawaiian Study Commission was authorized, 94 Stat. 3321 (1980)

—Native Hawaiians included as a eligible class for services under the Job Training Partnership Act, P.L. 97–300 (1982).

—Secretary of Health and Human Services directed to conduct a comprehensive study of the health care needs of Native Hawaiians, P.L. 98–396 (1984).

—Native Hawaiians included as eligible class for services in Carl D. Perkins Vocational Education Act, P.L. 98–524 (1984)

—Native Hawaiians included as an eligible class for services under Library Services and Construction Act Amendments, P.L. 98–480 (1984).

—Native Hawaiians included as a eligible class for whom priority was provided in Institutional Aid programs in Higher Education pursuant to the Conference Report on Fiscal Year 1985 Appropriations for the Departments of Labor, Health, and Human Services, and Education, Conf. Rept. No. 98–1132, (1985).

—Native Hawaiians included as a eligible class for whom priority was provided in the creation of Parental-Child Development

Centers pursuant to the Conference Report on Fiscal Year 1985 Appropriations for the Departments of Labor, Health, and Human Services, and Education, Conf. Rept. No. 98-1132, (1984).

—Native Hawaiians included as eligible class for services in Anti-Drug Abuse Act of 1986, P.L. 99-750 (1986).

—Grant authorized for Native Hawaiian Culture and Arts Development Program in Higher Education Amendments of 1986, P.L. 99-498 (1986).

THE BASIS OF THE FEDERAL-HAWAIIAN NATIVE RELATIONSHIP

Most commentators and courts that have explored the question of the Federal-Hawaiian Native trust relationship have concluded that although the perimeters are not defined, as they are also not completely defined for Indians, such a trust relationship exists.[7] It is based on the dependency of the indigenous Hawaiian Natives, and the recognition by the United States Congress of that status in the annexation of Hawaiian Islands, the establishment of the Hawaiian Homes Commission, and the Hawaiian Admissions (statehood) Act.

Felix Cohen's Handbook on Federal Indian Law[8] is the most prestigious and comprehensive treatment of legal theory and case law pertaining to Native Americans in the field. The 1982 edition says of Native Hawaiians:

> . . . they are a people indigenous to the United States . . . however . . . they have not been dealt with comprehensively by Congress.
>
> * * * * * * *
>
> . . . the full extent of the trust obligation owed by the United States to Native Hawaiians and the manner of its fufillment has not been fully defined.[9]

The Congressional Research Service in response to a request from Senator Inouye reviewed the question and concluded:

> The courts have upheld the power of Congress to single Indians out for special treatment because of their unique status under the Constitution and treaties, and have inferred a trusteeship obligation on the part of the United States toward the aboriginal people that constitute the original inhabitants of lands now within the borders of the continental United States. . . . The same reasoning that was used to infer a trust relationship between the United States government and the Indian tribes would seem to be capable of being applied to the relationship with Native Hawaiians.[10]

---

[7] The Hawaiian Study Commission majority report acknowledges a "very limited special trust" and the minority report argues for a broader trust. Either view would support rationally related services.

[8] 1982 Edition.

[9] *Ibid*, at 797-798.

[10] November 2, 1983 memorandum from the Congressional Research Service, Library of Congress, to Senator Daniel K. Inouye, *Definition of Native Hawaiians*, 1-2.

Several federal courts and the Supreme Court of Hawaii have had to address the issue of whether a trust relationship exists for Native Hawaiians and all have concluded that it does. Perhaps the most misunderstood case in the area is *Keaukaha-Pananewa Community Association* v. *Hawaiian Homes Commission*,[11] known as *Keaukaha I*. This case considered whether a group of Native Hawaiians had standing as private parties to bring suit in federal court under the Hawaiian Homes Commission Act and/or the Hawaiian Admissions Act to prevent the Commission from transferring certain trust lands. Although the Court was clear that a trust for the benefit of Native Hawaiians had been established by these Acts, the administration of which was primarily with the state of Hawaii, the Court determined that a Federal question did not exist and that state court was the proper forum. In reaching that conclusion the 9th Circuit stated:

> It is clear, however, that for all practical purposes these benefits have lost their federal nature.[12]

It has been suggested that this dicta of the 9th Circuit may be a barrier to asserting a Federal-Hawaiian Native Trust relationship. The statement or dicta should be understood in the context of *Keaukaha I* being a case pertaining to availability of remedies, not a case defining rights. The unavailability of a currently viable remedy does not negate the fact that a right exists. Paradoxically, rights and remedies do not necessarily run together. It is quite clear in federal Indian law that many Indian "rights" have been what Justice Frankfurter once termed "hortatory". Special acts of Congress have been required to vindicate such rights.[13] The fact that a number of Indian rights currently require remedies in State forums rather than Federal forums does not convert the Federal Indian right into a State right.[14]

A more recent case involving the identical underlying factual issues and parties as *Keaukaha I*, known as *Keaukaha II*[15] determined that the trust relationship reflected in the Hawaiian Homes Commission Act and the Hawaiian Admissions Act was a federal right enforceable under the 42 U.S.C. Sec. 1983, a reconstruction era civil rights statute. This decision should end any confusion over Hawaiian rights that remained under *Keaukaha I*. Section 1983 actions are premised on the deprivation under the color of state law of a federal right. The Federal right required for the application section 1983 is the finding that the Hawaiian Admissions Act clearly "mandates the establishment of a trust for the betterment of native Hawaiians."

The Supreme Court of Hawaii in *Ahuna v. Department of Hawaiian Home Lands*, 64 Haw. 327, 640 P. 2d 1161 (1982) also has addressed the issue of Federal-Hawaiian Native Trust relationship in order to determine the obligations of the Hawaii State Department of Hawaiian Home Lands in administering the lands that had been

---

[11] 588 F.2d 1216 (9th Cir. 1978).

[12] Ibid, at 1226.

[13] The establishment of the Indian Claims Commission was in direct response to the inability to otherwise pursue claims.

[14] See e.g., P.L. 83-280 which permitted states to assume specified jurisdiction over Indians.

[15] Keaukaha-Panaewa Community Association v. Hawaiian Homes Commission, 739 F.2d 1467 (9th Cir. 1984).

set aside by Congress for Native Hawaiians in the Hawaiian Homes Commission Act. The Court determined that: (1) the legislative history of the Hawaiian Homes Commission Act indicates that the United States "stood in a trusteeship capacity to the aboriginal people" of Hawaii; and (2) the primary purpose of the Act "was the rehabilitation of native Hawaiians". The Hawaiian Supreme Court then utilized Federal-Indian law to determine the state agency's fiduciary obligation, as the instrumentality for effectuating the Federal purpose.

Also implicit in the *Ahuna* decision is the determination that special programs for the benefit of Native Hawaiians are not constitutionally suspect racial discrimination. The applicable principles of analysis are from Indian law. The U.S. Supreme Court determined in *Morton* v. *Mancari* [16] a federal employment preference for Indians was not unconstitutional racial discrimination, but rather a reasonable exercise of federal discretion to implement its trust relationship with Indians. Indians for the purposes of the trust relationship are not a "race", but rather what has been termed a political classification. Case law indicates that programs, functions or services need only be "rationally related" to the purposes of the trust to pass constitutional muster.[17]

The Attorney General of the State of Hawaii had to address the question of potential unconstitutional discrimination when the State of Hawaii established the Office of Hawaiian Affairs, all of whose trustees must be Native Hawaiians, and elected by Native Hawaiians. Utilizing Indian law principles, the Attorney General of Hawaii in a written advisory opinion, (Opinion No. 80–8, July 8, 1980) determined that the Office of Hawaiian Affairs was a rational means of effectuating the state's obligations under the trust relationship to Native Hawaiians. This judgment is consistent with federal and state judicial decisions sustaining state action that are carried under federal authority to further the Federal trust responsibility.[18]

THE HISTORICAL RELATIONSHIP

A review of the history of relations between Hawaiian Natives and the United States demonstrates that there are significant parallels to aspects of U.S.-Indian history and gives credence to the observations of the commentators and the Courts that a Federal-Native Hawaiian Relationship exists.

It has been estimated that approximately 300,000 native people occupied the "Sandwich Islands", as Hawaii was then called when Western society discovered them in 1778. The indigenous Hawaiians had a complex political and economic but self-sufficient system in existence at time of contact. The system has been compared to the feudal system of medieval Europe. Private property—fee simple title—did not exist. Land occupancy rights ran from greater lords to lesser lords to commoners; obligations ran in reverse order.[19]

---

[16] Morton v. Mancari, 417 U.S. 535 (1974).

[17] Delaware Tribal Business Council v. Weeks, 430 U.S. 73 (1977).

[18] See, R. Johnson and E.S. Crystal, Indians and Equal Protection, 54 Wash. L. Rev. 587 (1979).

[19] N. Levy, Native Hawaiian Land Rights, 63 Cal. L. Rev. 848 (1975) provides an extensive discussion of these matters and is relied upon throughout this paper.

Major differences did exist: land use rights were personal and did not necessarily pass to heirs; and "commoners" were not tied to the specific lords or land and could move. Each island was autonomous until 1810 when Kamehameha I united the Islands by conquest and negotiation.

Certain similarities to the Indian situation at the time of discovery are pertinent. Both populations were politically autonomous, and both populations were self-sufficient in their traditional economies and life styles. Neither population had a private property system; but they did however control most, and in some cases all, of the lands within their political boundaries.

All of these situations would change. The various ways that Indians lands have been alienated from Indian ownership has been documented in proceedings of the Indian Claims Commission, and other sources. Interestingly, treaties which have become a major source of evidence in establishing a trust relationship, were often the instruments of land loss. The role of the United States in these transactions was fairly clear, it either directly obtained the Indian land or failed to protect the tribes in their land dealings.

The role of the United States in the Hawaiian loss of land was different in form than in the Indian situation but just as central. Treaties with the Native Hawaiian government were not generally land transactions but were means of assuring commercial access. The first treaty of peace and friendship proposed in 1826 was not ratified by the United States.[20] The first ratified treaty (1849)[21] dealt with friendship, commerce and navigation. A second treaty was entered into in 1875; dealing with commercial reciprocity.[22] A final treaty, also concerning commercial reciprocity was entered into in 1884.[23] Throughout the 19th century, it would be the American merchants along with American missionaries who under the auspices of "civilizing" a system they felt was culturally inferior to their own would intervene with the military support of the United States government in internal Hawaiian affairs. This active intervention first focused on access to Hawaiian commercial timber, then after the trees were depleted switched to access to the land itself for the establishment of the plantation economy that would dominate Hawaii in the second half of the nineteenth century. This interference would find only expression in the western style constitution of 1840 and culminate in an insurrection against the Hawaiian monarchy.

During the first half of the 19th century, the merchants were supported by their respective Governments (French, British and American) by the use of naval war ships[24]. In effect the Westerners, and eventually the United States, using the threat of military force reduced the Kingdom of Hawaii to the functional equivalent of a dependent sovereign—a suzerainty.

---

[20] Treaty with Hawaii on Commerce. Dec. 23, 1826, United States-Hawaii, 3 C. Bevans, Treaties and Other Internal Agreements of the United States, 1776–1949, p. 861 (1971).

[21] Treaty with Hawaii on Friendship, Commerce and Navigation, Dec. 20, 1849, U.S.-Hawaii, 9 Stat. 977.

[22] Treaty with Hawaii on Commercial Reciprocity, Jan. 30, 1875, U.S.-Hawaii, 19 Stat. 625.

[23] Treaty with Hawaii on Commercial Reciprocity, Dec. 6, 1884, U.S.-Hawaii, 25 Stat. 1399.

[24] Levy, *supra*, n.16 at 852.

The influence of the western powers was greatly felt in the land system:

> By 1845, the land tenure system could neither maintain itself in the fact of a hostile foreign world or accommodate itself to the wishes of the world.[25]

A land Commission dominated by Westerners was appointed. It would oversee the "Great Mahele"; the end of the traditional Hawaiian land system and the substitution of a more western style system of fee ownership. Cohen points out that:

> By destroying the interlocking communal nature of land tenure its [the Great Mahele] effect was similar to allotment and termination acts on the mainland.

Land rights were concentrated in the hands of the very few. The King and the chiefs held title to 99 percent of all the lands. Many of the commoners who lived on the land were not permitted a realistic opportunity to obtain title to their lands. In a process not dissimilar to that which occurred with Indian lands after allotment, title to much of land was soon transferred to non-Hawaiian ownership. Large plots of lands owned by royalty no longer had communal obligations attached and were therefore not productive without western capital or management systems. They were sold off at "distress prices" and fraud was not uncommon; ultimately a plantation economy with imported non-Hawaiian labor was firmly established. Small plots were also uneconomical and most were soon lost.

All commentaries seem to agree that in the second half of the 19th Century a small number of Westerners (2,000) came to control most of the land in Hawaii:

> Native Hawaiians had been excluded from the mainstream of the economy; they had lost ownership of most privately held land and had been reduced to a minority of the inhabitants of the Kingdom.[26]

Control of land, however, was not enough. The Westerners who by the latter part of the nineteenth century were primarily Americans, sought political control. As noted previously the first Hawaiian constitution of 1840 was procured by western influence. The constitution of 1887, known as the "Bayonet Constitution" was forced on the Monarchy by armed merchants—American citizens. This constitution restricted the right to vote to those who paid taxes, including non-citizens. Native Hawaiians were disenfranchised and the American merchants obtained a virtual dictatorship.

At this point, although legally part of foreign state, the American merchants felt that they were "part of the American system"; a view publicly echoed by U.S. Secretary of State Blaine. However, the imposition of the "McKinely tariff" on foreign sugar (including Hawaiian sugar) created a significant economic crisis. Sugar fell from $100 a ton to $60 a ton and property values collapsed in Hawaii.[27]

---

[25] *Ibid*, at 853.
[26] Cohen, *supra*, n.8, at 800.
[27] S. Morrison and H.S. Commanger, The Growth of the American Republic, 5th Ed., Vol. 2 (1962).

The last royal ruler of Hawaii, Queen Liliuokalani, came to the throne in 1892 and attempted to replace the "Bayonet constitution" with a new one that would have significantly eroded western power. Foreigners were to be precluded from obtaining citizenship or from voting. In January 1893, shortly before the new constitution was to go into effect, and while President Harrison, who favored annexation, was still in office, armed American merchants, aided by the U.S. minister in Hawaii, John L. Stevens, and marines from the U.S.S. *Boston* forced the Queen to relinquish her governmental authority.

A provisional government dominated by American merchants was established. This government immediately sought annexation by the United States. The goal of annexation, however, would take a few years. Assuming office shortly after the overthrow of the Queen, President Cleveland, supported by the Blount report[28] refused to support annexation.[29] The Blount Report found that the overthrow of the Queen had been illegal; and recommended that she be restored to power. The Provisional government of Hawaii refused to follow Blount's recommendations and instead established the Republic of Hawaii. The Republic thereupon took over all crown and government lands without compensation.

Another report on the overthrow of the Queen and the propriety of annexation would be prepared by the Senate Foreign Relations Committee; it is known as the Morgan Report.[30] The Morgan Report approved the United States support of the merchants. It used a familiar theory . . . determining Hawaii to be a dependent sovereignty of the United States. An analogus theory to that used in the landmark decisions that gave judicial recognition to the Federal-Indian relationship, *Worcester* and *Cherokee Nation.* The report stated:

> [It] is a recognized fact that Hawaii has been all the time under a virtual suzerainty of the United States . . . a de facto supremacy over the country.

A "suzerainty" was understood in International law to be the relationship that a more powerful sovereign has over a dependent one; the dependent sovereign was usually viewed as less "civilized" than the powerful sovereign.

After the Morgan Report, by a joint resolution of Congress the United States annexed Hawaii in 1898,[31] Cohen states that with annexation "Native Hawaiians became a dependent indigenous people of the United States."[32]

Native Hawaiian conditions which were stressed at the time of annexation continued to deteriorate. Indian conditions were at same time also suffering from similar circumstances; loss of traditional life styles and food resources; loss of the native land base; and destruction of traditional modes of self-government. By the

---

[28] James Blount the former Chairman of the House of Representatives Committee on Foreign Affairs, appointed as Special Commissioner to Hawaii. See Kuykendall. *The Hawaiian Kingdom, The Kalakaua Dynasty* (1967) for an in depth treatment of this era in Hawaiian affairs.

[29] President's Message Relating to the Hawaiian Islands, H.R. Exec. Doc. No. 47, 53rd Cong., 2d Sess., XIV-XV (1893).

[30] S. Rep. No. 227, 53rd Cong., 2d Sess. (1893).

[31] 30 Stat, 750 (1898).

[32] Supra, n. 8, at 802.

1920's, reformers were concerned about the conditions of Native people. For Indians, the Red Cross survey of conditions, and the Meriam Commission report would result in a partial reversal of many of the policies of the 19th century.

For Hawaiians Natives the concern would focus in the Hawaiian Homes Commission Act.[33] The Act set aside 200,000 acres of land to be leased at nominal rates for 99 years to Native Hawaiians. Congress viewed the Hawaiian Homes Commission as a "plan for the rehabilitation of the Hawaiian Race." The bill was introduced by the nonvoting Delegate from Hawaii, J.K. Kalanianole, a member of the royal family of Hawaii based on a plan developed by Senator Wise of the Legislative Commission of the Territory of Hawaii.

The Hawaiian Homes Commission Act also addressed another concern prevalent at the time. This was the concern of many of "growers" whose long term leases on their plantations were expiring, that under the homesteading laws applicable in the territories, that much of "their land" could be lost to homesteading. These hundreds of thousands of agricultural acres were removed from the Homesteading provisions.

Hawaiians were thought to be a dying race, numbering a scant 22,500 in 1920. The House Committee Report [34] on the Homes Commission quotes from the hearing record to establish the cause of the problem it was attempting to remedy.

> Secretary [of the Interior] LANE. One thing that impressed me . . . was the fact that the natives of the islands who are our wards, I should say, and for whom in a sense we are trustees, are falling off rapidly in numbers, and many of them are in poverty . . .
>
> * * * * * * *
>
> Mr. MONAHAN. What caused this dying away of the race . . .
>
> Secretary LANE. . . . It is always incident to the comings of civilization and we always carry disease germs with us to which these people are not immune . . .

The Committee's response to any challenge to the bill's constitutionality's as "unconstitutional class legislation" was to point out, among other arguments, that Congress had the authority to provide special benefits for unique groups such as "Indians, soldiers and sailors . . .". This is the same argument in embryonic form, that the Supreme Court would later use in *Morton* v. *Mancari* to sustain special programs for Indians. The Hawaiian Homes Commission Act is universally viewed as Congress' recognition of the special relationship the United States has to Native Hawaiians.

When Hawaii became a state in 1959, the dominant federal-Indian policy was then the termination of Indian reservations and the transfer of much Federal administrative responsibility to States. It is therefore not surprising that the Hawaiian Homes Commission was made part of the responsibilities of the State of

---

[33] 42 Stat. 108 (1921).
[34] H.R. Rep. No. 839, 66th Cong., 2d Sess. 4 (1920).

Hawaii upon Hawaii's admission to the union. Since the rights involved were Federal, Federal responsibility was retained. Any changes proposed by the State that could impair Hawaiian Native rights require Congressional consent, and the United States is the only party with specific standing to sue in federal courts to enforce the provisions of the trust.[35]

Another important provision was also included in the Admission Act that demonstrates Congresses' denotation of Native Hawaiians as a special beneficiary group. That provision, required the State of Hawaii to utilize the income and proceeds from lands the United States ceded to Hawaii for the benefit of the people of Hawaii, and specifically Native Hawaiians. Again the United States retained a supervisory trustee role.[36]

Since statehood Congress has periodically legislated for the benefit of Native Hawaiians.[37] It has not, however, comprehensively addressed Hawaiian Native issues. This situation is not entirely different from the Federal-Indian relationship, which also has not been comprehensively spelled out. Many of the Indian programs are premised on general statutory authority. The Executive branch has been allowed great latitude in defining the nature and scope of programs.[38] Absent an express direction from Congress, the agencies operating federal programs have not included Hawaiian Natives. Although it is possibly administratively feasible to include Hawaiian Natives, given the broad discretion asserted by federal agencies, inclusion of the Hawaiian Native population in federal programs by agency action is not very likely. Department of the Interior regulations on tribal recognition apply only in the continental United States and therefore exclude Hawaiians.[39] Furthermore much agency activity in the last decade has focused on reducing beneficiaries by narrowing eligibility criteria.

In many ways, native Hawaiian issues resemble those of Native Alaskans prior to the Alaskan Native Claims Settlement Act. In addressing the issue of whether "Eskimos" were "Indians" even though not of the same racial origin, courts have determined that the term "Indians" is not a racial classification but a term of art for the aboriginal peoples of America.[40] "Alaskan Natives were sometimes included in Indian programs, although not always. Periodically programs were passed for Alaskan Natives that did not have Indian counterparts.[41] Alaskan Natives with several exceptions did not have reservations or trust lands. In addition to resolving Alaskan land claims, the Settlement Act provided for a comprehensive definition of Alaskan Natives, and the creation of a series of entities, including existing traditional Native villages, as the mechanisms for land holding as well as service delivery. These mechanisms which have no counterpart in Indian affairs in the

---

[35] P.L. 86-3, set out in full in 48 U.S.C. prec. sec. 491.
[36] 73 Stat. 4, sec. 5(f) (1959).
[37] See the discussion on pages 6-7.
[38] *Morton* v. *Ruiz*, 415 U.S. 199, 231 (1974) "the power of an administrative agency to administer a congressionally created and funded program necessarily requires the formulation of policy and the making of rules to fill any gap left implicity or explicity by Congress."
[39] 25 C.F.R. 54.2.
[40] *Pence* v. *Kleppe*, 529 F.2d 135 (9th Cir. 1976)
[41] For example the importation of Reindeer for benefit of Alaskan Natives, 25 U.S.C. sec 500.

lower-forty eight states, but have become routine parts of the Federal-Alaskan Native relationship.

Many distinct issues, and many divergent views exist on the subject of Hawaiian Lands Claims. Absent such a comprehensive approach to Hawaiian issues, as was provided for Alaskan Natives by the Alaskan Claims Settlement Act, or some other comprehensive mechanism, Congress will on a by-case basis whether any particular program should be part of the Federal-Hawaiian relationship. As Cohen has stated " . . . there is no reason to doubt that Congress has power to legislate specifically for the benefit of Native Hawaiians".[42]

SECTION-BY-SECTION ANALYSIS

Section 1. Section 1 contains the findings of the Congress with regard to the present status of Native Hawaiian health.

Section 2. Section 2 contains definitions of the terms used in the Act, including the terms "disease prevention", "health promotion", "Native Hawaiian", "Native Hawaiian organization", "Native Hawaiian educational institution", "Papa Ola Lokahi", "Secretary", and "Traditional Native Hawaiian Healer".

Section 3. Section 3 authorizes the Secretary of Health and Human Services to enter into contracts with Native Hawaiian organizations so that such organizations may, pursuant to their contracts with the Secretary, establish and administer programs of health promotion and disease prevention which are designed to serve Native Hawaiians. Papa Ola Lokahi, the Native Hawaiian Health Board, shall be the entity responsible for certifying to the Secretary that a Native Hawaiian organization has the qualifications and capacities necessary to carry out the terms of the contract, and to administer health promotion and disease prevention programs. The establishment of health promotion and disease prevention programs is to follow and be fully consistent with a Native Hawaiian health care master plan, which is to be conducted by a Native Hawaiian organization under a grant from the Department of Health and Human Services, based upon the conduct of assessments of health status and health care needs in the Native Hawaiian communities desiring to participate in the Native Hawaiian Healing Centers.

The health promotion and disease preventions programs authorized in section 3 shall be part of Native Hawaiian Healing Centers that are proposed to be established on the islands of O'ahu, Moloka'i, Maui, Hawai'i, Lana'i, Kaua'i and Ni'ihau, upon the acceptance of and following consultation with the Native Hawaiian communities on those islands wishing to participate. The health promotion and disease prevention programs shall provide: (1) comprehensive preventive-oriented health services, including maternal and child health care and mental health care, through the establishment of Native Hawaiian healing centers, subject to the availability of appropriations; (2) for the collection of data related to the prevention of diseases and illnesses among Native Hawaiians, including the prevention of fetal alcohol syndrome, hypertension,

---

[42] Supra, n. 8, at 803.

heart disease, and diabetes; (3) for medical and general health-related research into the diseases that are most prevalent among Native Hawaiians including, but not limited to heart disease, hypertension, cancer, and diabetes; (4) for research into the mental health problems that are most prevalent among Native Hawaiians including but not limited to alcoholism, substance abuse, reduction of stress, and child abuse; (5) for education in health promotion and disease prevention in the Native Hawaiian population by Native Hawaiian community outreach workers, nurses, counselors, cultural educators and health aides, and Non-Hawaiian nurses serving the Native Hawaiian community; (6) for health planning in areas which shall include but not be limited to health planning in maternal and child health, nutrition, disease prevention, health promotion, health education, and mental health; (7) for the provision of health care services by traditional Native Hawaiian healers; and (8) training for Native Hawaiian community health outreach workers, nurses, counselors, cultural educators and health aides, and Non-Hawaiian nurses serving the Native Hawaiian community in the provision of health care and health education in Native Hawaiian communities by means of a curriculum which combines education in the theories of health care with supervised practical experience in the provision of health care, which provides instruction and practical experience in health promotion and disease prevention activities, particularly nutrition, physical fitness, weight control, cessation of tobacco smoking, stree management, control of alcohol and substance abuse including the prevention of fetal alcohol syndrome, control of high blood pressure, prevention and control of diabetes, prevention of lifestyle related accidents, prenatal and postnatal infant health care, and maternal health care, and which provides instruction in the most current and effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits.

Section 3 also authorizes the Secretary to enter into an agreement with a native Hawaiian organization or Native Hawaiian educational institution, for purposes of assigning Department of Health and Human Services personnel to the Native Hawaiian organization on a detail basis for the purpose of providing education in health promotion and disease prevention to Native Hawaiian children who are underserved. The assignment is to be treated as an assignment of Federal personnel to a local government that is made in accordance with subchapter VI of chapter 33 of title 5, United States Code.

Section 3 authorizes the Secretary to include in contracts authorized in section 3, any terms or conditions that the Secretary may deem necessary to ensure that the objectives of the contract are achieved. Further, the Secretary is authorized to develop procedures to evaluate contract compliance and performance, and to conduct evaluations of contract compliance and performance. If the Secretary finds a lack of compliance or less than satisfactory contract performance, the Secretary may attempt to resolve the areas of noncompliance or unsatisfactory performance prior to renewing a contract. If the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved or prevented in the future, the Secretary may refuse to renew the contract, and may

enter into a contract with another Native Hawaiian organization provided that Native Hawaiian organization provides services to the same Native population served under the nonrenewed contract.

Contracts are to accord with Federal contracting laws and regulations, except that in the discretion of the Secretary, contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (40 U.S.C. 270a, et seq.). Contract payments may be made in advance by reimbursement or in installments, based on the conditions the Secretary may deem necessary to carry out the purposes of section 3. At the request of a Native Hawaiian organization, the Secretary may revise or amend any contract. If a Native Hawaiian organization requests termination of a contract, the termination shall become effective upon a date specified by the Secretary. A Native Hawaiian organization contracting with the Secretary must submit quarterly reports to the Secretary on activities conducted under the contract, the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may require. The reports and records of a Native Hawaiian organization contracting with the Secretary shall be subject to audit of the Secretary and the Comptroller General of the United States. An allowable cost of the contract entered into pursuant to section 3 is the cost of an annual private audit conducted by a certified public accountant. The Secretary's authority to enter into contracts pursuant to section 3 shall be to the extent and in amount provided for in appropriation Acts.

Section 4. Section 4 authorizes the Secretary to establish Native Hawaiian Healing Centers on the islands of O'ahu, Moloka'i, Maui, Hawaii'i, Lanai'i, Kaua'i, and Ni'ihau in the State of Hawaii for the purpose of providing comprehensive health promotion and disease prevention services as well as primary health care services to Native Hawaiians, and wherever practicable, to establish such Centers within existing facilities, or where no such facilities exist, to enter into a contract with a Native Hawaiian organization for the establishment of a Native Hawaiian Healing Center in a new facility, upon submission of a report by the Native Hawaiian organization which sets forth a proposed plan for a new facility, a justification of the need for a new facility, and the anticipated costs of construction.

Section 4 also authorizes the Secretary to provide planning grants to Native Hawaiian organizations (provided that there are no more than 7 such grants in the amount of $100,000 per grant) for the purpose of planning Native Hawaiian Healing Centers to serve the health needs of Native Hawaiian communities.

Section 4 authorizes the Secretary to require that Native Hawaiian Healing Centers: (1) conduct a health care needs assessment in each Native Hawaiian community that desires to participate in the Center, including a determination of the population of Native Hawaiians to be served by the Center, the current health status of Native Hawaiians served by the Center, and the current health care needs of Native Hawaiians served by the Center; (2) develop a comprehensive master plan for the provision of training and services based on the health status and health care needs assessment; and, recognizing that there will be certain health care services that may not be available within the Center, (3) provide health care re-

ferral services to Native Hawaiians who are or could be recipients of health care referral services based on the health status and health care needs assessment, and assist Native Hawaiians in becoming familiar with such health services and resources and in utilizing such health service resources, following: (a) the identification by the Center of all public and private health service resources which are or could be available to Native Hawaiians; and (b) a determination of the use of public and private health service resources by Native Hawaiians served by the Center.

Section 4 authorizes appropriations in the amount of $700,000 for fiscal year 1990 for the purpose of providing planning grants; and $2,800,000 for fiscal year 1991 for the purpose of establishing no more than 7 Native Hawaiian Healing Centers to serve the health needs of Native Hawaiian communities, such sums to remain available until expended. No more than $525,000 of the funds authorized to be appropriated may be expended for each Native Hawaiian Healing Center.

Section 5. Section 5 authorizes the Secretary, in consultation with Native Hawaiian organizations, to conduct a study of any barriers which may exist to the participation of Native Hawaiians in programs established under title XVIII of the Social Security Act (Medicare) or under title XIX of the Social Security Act (Medicaid). Section 5 further authorizes the Secretary to submit a report to the Congress within two years of the date of enactment of the Act which is to include: (1) recommendations for legislation which would remove any barriers to participation identified in the Secretary's study, and which would encourage participation by Native Hawaiians in Medicare and Medicaid, as well as estimates of the potential number of Native Hawaiians that are eligible for Medicare or Medicaid, and the number of Native Hawaiians that are participating in each program.

Section 6. Section 6 authorizes appropriations for fiscal year 1990 and for each fiscal year thereafter in the amount of such sums that may be necessary to carry out the provisions of this Act for which a specific authorization of appropriations is not otherwise provided for in the Act.

Section 7. Section 7 authorizes the Secretary to make a grant under section 720(a)(1) of the Public Health Service Act to the University of Hawaii in Honolulu, Hawaii for the construction of a building for a Pacific Basin disease research institute. Further, section 7 provides that notwithstanding sections 702(b) and 721(c) of the Public Health Service Act, the Secretary is not required to secure the advice of the National Advisory Council on Health Professions Education with respect to such grant. The Federal share of the necessary costs of construction, as determined by the Secretary, of the building is to be fifty percent. To carry out the purposes of section 7, $5,000,000 is authorized to be appropriated for any one fiscal year. Amounts appropriated under section 7 are to remain available until expended.

LEGISLATIVE HISTORY

S. 136 was introduced on January 6, 1987, by Senator Inouye for himself and Senators DeConcini and Matsunaga, and was referred

to the Select Committee on Indian Affairs. A hearing on S. 136 was held in Honolulu, Hawaii on March 6, 1987.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

The Select Committee on Indian Affairs, on March 19, 1987, in open business meeting, by a unanimous vote with a quorum present, recommended that the Senate pass S. 136, a bill to improve the health status of Native Hawaiians. The Committee met again on September 30, 1988 to consider an amendment in the nature of a substitute to S. 136, and in open business meeting, by a unanimous vote with a quorum present, recommends that the Senate pass S. 136, as amended.

COST AND BUDGETARY CONSIDERATIONS

The cost and budgetary impact of S. 136, as evaluated by the Congressional Budget Office, is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC., September 30, 1988.

Hon. DANIEL K. INOUYE,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 136, a bill to improve the health status of Native Hawaiians, as ordered reported by the Senate Select Committee on Indian Affairs on September 29, 1988.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JAMES L. BLUM,
Acting Director.

CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE

1. Bill number: S. 136.
2. Bill title: None.
3. Bill status: As ordered reported by the Senate Select Committee on Indian Affairs on September 29, 1988.
4. Bill purpose: To improve the health status of Native Hawaiians.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1989	1990	1991	1992	1993
Estimated authorization levels:					
Health Promotion and Disease Prevention (HPDP) Program	7.2	7.5	7.8	8.1	8.4
HPDP Master Plan		0.7			
Native Hawaiian Healing Centers Planning Grants		0.7			
Native Hawaiian Healing Centers			2.8		
Medicare/Medicaid Access Study	0.3				
Pacific Basin Disease Research Institute	5.0				
Total Estimated Authorization Level	12.5	8.9	10.6	8.1	8.4
Total Estimated Outlays	7.0	8.9	9.9	9.1	8.6

The costs of this bill fall within budget function 550.

Basis of estimate: S. 136 states authorization levels for the HPDP master plan, the Native Hawaiian healing centers and planning grants, and the Pacific Basin Disease Research Institute. The bill authorizes such sums as may be necessary to carry out all remaining provisions. Activities authorized in the bill without stated authorization levels have been estimated by CBO. The CBO assumes that all authorizations are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

The health promotion disease prevention program would have four basic functions that CBO estimates would result in additional costs to the federal government: data collection, research, health planning, and community outreach. The CBO estimates the total costs of the HPDP program to be $7.2 million in fiscal year 1989, increasing to $8.4 million in fiscal year 1993. Bill language concerning HPDP program implementation is not specific. Costs for this program could vary depending on exactly how the program is implemented.

As part of the HPDP program, the bill authorizes data collection on disease prevention among Native Hawaiians. The federal government currently operates a similar system that collects and analyzes data on smoking at a cost of about $2 million each year. Similar costs could be expected to result from disease prevention data collection. In addition, the program would provide for research into diseases and mental health problems most prevalent among Native Hawaiians. The CBO assumes three researchers would be supported every year at a total annual cost of $550,000. This estimate is based on the average annual research award of $175,000 provided by the National Institutes of Health. Education in health promotion and disease prevention in the Native Hawaiian population would be provided by community outreach workers and native Hawaiian nurses at a negligible additional cost to the federal government.

Health planning activities authorized as part of the HPDP program might be accomplished by establishing a main health planning board consisting of five members with an additional health planner on each of the seven Hawaiian islands. This type of health planning board would cost $800,000 to $900,000 in each fiscal year. The bill authorizes the HPDP programs to employ Native Hawaiian community health outreach workers and train them as paraprofessionals in the provision of health care and health education. Assuming ten workers were employed at each of the eight HPDP sites and that workers were trained to the level of certification of medical assistants, costs for salary, overhead and training could cost about $4 million in each fiscal year 1989 through 1993.

Another section of the bill authorizes the Secretary of Health and Human Services (HHS) to assign personnel on detail to Native Hawaiian organization educational institutions to provide HPDP education. There is one central Native Hawaiian educational institution and 28 Native Hawaiian education programs in outlying areas. If four employees were assigned on detail, about $300,000 for salary and overhead would be redirected in each fiscal year from HHS's current activities to health promotion and disease prevention education in Hawaii.

Costs for the one-year study on access to Medicare and Medicaid services are estimated to be $300,000 in fiscal year 1989 only.

6. Estimated cost to State and local government: None.

7. Estimate comparison: None.

8. Previous CBO estimate: The CBO prepared an estimate of S. 136 as ordered reported by the Senate Select Committee on Indian Affairs on March 19, 1987. The original version of this bill had a number of provisions that have been deleted in the current bill.

9. Estimate prepared by: Lori Housman.

10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

EXECUTIVE COMMUNICATIONS

The Committee received no communications from the Executive branch of government on S. 136.

REGULATORY AND PAPERWORK IMPACT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 136, as amended, will have a minimal impact on regulatory or paperwork requirements.

CHANGES IN EXISTING LAW

S. 136 effects no changes in existing law.

○